



## State of Tennessee

### Health Services and Development Agency

Andrew Jackson Building, 9<sup>th</sup> Floor, 502 Deaderick Street, Nashville, TN 37243  
 www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

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**Date: November 7, 2014**

**To: HSDA Members**

**From: Melanie M. Hill, Executive Director**

**Re: CONSENT CALENDAR JUSTIFICATION  
 CN1409-039 Princeton Transitional Care**

As permitted by Statute and further explained by Agency Rule later in this memo, I have placed this application on the consent calendar based upon my determination that the application appears to meet the established criteria for granting a certificate of need. Need, Economic Feasibility and Contribution to the Orderly Development of Health Care appear to have been demonstrated as detailed below. If Agency Members determine that the criteria have been met, a member may move to approve the application by adopting the criteria set forth in this justification or develop another motion for approval that addresses each of the three criteria required for approval of a certificate of need. If you find one or more of the criteria have not been met, then a motion to deny is in order.

At the time the application entered the review cycle on July 1, 2014, it was not opposed. If the application is opposed prior to it being heard, it will be moved to the bottom of the regular November agenda and the applicant will make a full presentation.

#### **Summary—**

This application proposes to relocate the existing 34-bed skilled nursing home from the James H. and Cecile C. Quillen Rehabilitation Hospital located at 2511 Wesley Street in Johnson City (Washington County), TN 37601 to Johnson City Medical Center located at 400 North State of Franklin Road in Johnson City, TN 37604, a distance of approximately 4 miles. The estimated project cost is \$21,000.

The decision to relocate the skilled nursing home is two-fold. First is the immediate need to expand rehabilitation services at Quillen. Mountain States will partner with HealthSouth to expand rehabilitation services. A joint venture will be established, clinical services will be expanded, and a certificate of need will most likely be filed in the future to expand rehabilitation beds. Semi-private rehabilitation rooms will be converted to private rooms now, which necessitates Princeton's move to Johnson City Medical Center.

The second is the long-range plan to create an elder care campus at the North Side Hospital location that will ultimately combine the beds associated with Princeton (34) and Franklin Transitional Care (13), which is another skilled nursing home also owned by Mountain States Health Alliance. The North Side campus is adjacent to Quillen. Princeton's relocation to Johnson City Medical Center is an intermediate step in the process. Mountain States has partnered with Signature HealthCARE, an experienced long-term care provider, to help implement its long-range plans for the development of the elder care campus at the North Side. The elder campus will offer a continuum of care, including independent, assisted living, and skilled nursing care. Signature will manage Princeton in the interim.

In 2010, Mountain States relocated Princeton from North Side Hospital to Quillen (approximately 500 feet) and Franklin Transitional Care (Franklin) from Quillen to Johnson City Medical Center (4 miles). The license for the 13-bed Franklin is inactive now.

The project requires minimal construction and will be funded by cash reserves of the parent entity, Mountain States Health Alliance.

Please refer to the staff summary and the TDH report for a detailed narrative of the project.

#### **Executive Director Justification -**

I recommend approval based upon my belief the general criteria for a certificate of need have been met.

**Need-** Need is met, as this interim relocation is part of a long-range planning process with an ultimate goal of creating updated rehabilitation services and an elder care campus. The interim location being only 4 miles from the current location will continue to serve the same population in need of skilled nursing care.

**Economic Feasibility-** Economic Feasibility is met as this project will require only minor renovations costing approximately \$21,000 and will be funded by cash reserves of the parent company, Mountain States Health Alliance.

**Contribution to the Orderly Development of Health Care-** Orderly Development is demonstrated based upon the long-range planning process Mountain States utilized to make its decisions on how best to meet the needs of its customers. The aging baby boomer population demands access to skilled nursing and rehabilitation services so it can remain active. The interim relocation will permit continued access to these services while long-range plans can be implemented.

#### **Statutory Citation -TCA 68-11-1608. Review of applications -- Report**

(d) The executive director may establish a date of less than sixty (60) days for reports on applications that are to be considered for a consent or emergency calendar established in accordance with agency rule. Any such rule shall provide that, in order to qualify for the consent calendar, an application must not be opposed by any person with legal standing to oppose and the application must appear to meet the established criteria for the issuance of a certificate of need. If opposition is stated in writing prior to

the application being formally considered by the agency, it shall be taken off the consent calendar and placed on the next regular agenda, unless waived by the parties.

**Rules of the Health Services and Development Agency-- 0720-10-.05 CONSENT CALENDAR**

- (1) Each monthly meeting's agenda will be available for both a consent calendar and a regular calendar.
- (2) In order to be placed on the consent calendar, the application must not be opposed by anyone having legal standing to oppose the application, and the executive director must determine that the application appears to meet the established criteria for granting a certificate of need. Public notice of all applications intended to be placed on the consent calendar will be given.
- (3) As to all applications which are placed on the consent calendar, the reviewing agency shall file its official report with The Agency within thirty (30) days of the beginning of the applicable review cycle.
- (4) If opposition by anyone having legal standing to oppose the application is stated in writing prior to the application being formally considered by The Agency, it will be taken off the consent calendar and placed on the next regular agenda. Any member of The Agency may state opposition to the application being heard on the consent calendar, and if reasonable grounds for such opposition are given, the application will be removed from the consent calendar and placed on the next regular agenda.
  - (a) For purposes of this rule, the "next regular agenda" means the next regular calendar to be considered at the same monthly meeting.
- (5) Any application which remains on the consent calendar will be individually considered and voted upon by The Agency.

**HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING**  
**November 19, 2014**  
**APPLICATION SUMMARY**

NAME OF PROJECT: Princeton Transitional Care

PROJECT NUMBER: CN1409-039

ADDRESS: 400 North State of Franklin Road  
 Johnson City (Washington County), Tennessee 37604

LEGAL OWNER: Mountain States Health Alliance  
 303 Med Tech Parkway, Suite #303  
 Johnson City (Washington County), Tennessee 37604

OPERATING ENTITY: Signature Health CARE, LLC  
 12201 Bluegrass Parkway  
 Louisville, (Jefferson County), Tennessee 40299

CONTACT PERSON: Allison Rogers  
 (423) 302-3378

DATE FILED: September 15, 2014

PROJECT COST: \$21,000

FINANCING: Cash Reserves

REASON FOR FILING: The relocation of a 34 bed skilled nursing home. *The nursing home beds in this project are NOT subject to the 125 bed Nursing Home Bed Pool for the July 2014-2015 state fiscal year period.*

DESCRIPTION:

Princeton Transitional Care (PTC), located on the James H. and Cecile C. Quillen Rehabilitation Hospital satellite campus of Johnson City Medical Center is seeking approval on the Agency's *Consent Calendar* for the relocation of 34 licensed skilled nursing facility beds located at 2511 Wesley Street, Johnson City (Washington County) to the main campus of Johnson City Medical Center located at 400 North State of Franklin Road, Johnson City (Washington County), a distance of 4 miles. The project involves no change to Princeton Transitional

Care's or Johnson City Medical Center's licensed bed complement. No new services will be initiated and no services will be discontinued. The project is not subject to the 125-bed Nursing Home Bed Pool for the 2014-2015 state fiscal year period.

The applicant has been placed under CONSENT CALENDAR REVIEW in accordance with TCA 68-11-1608(d) and Agency Rule 0720-10-.05.

#### SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

#### **CONSTRUCTION, RENOVATION, EXPANSION, AND REPACEMENT OF HEALTH CARE INSTITUTIONS**

1. **Any project that included the addition of Beds, Services, or Medical Equipment will be reviewed under the standards for those specific activities**

*Not applicable to this application.*

2. **For relocation or replacement of an existing licensed health care institution:**
  - a. **The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.**

*Renovation was not an option for the applicant at the current location. Expansion of rehabilitation services is planned for the current location. The temporary relocation of PTC, a 34 bed SNF, to Johnson City Medical Center is needed as the applicant's long-term plan is to relocate to a future elder care community. The new elder care community will require 18-24 months of construction.*

*The cost of the project is \$21,000 and no other alternative would be as cost effective.*

*The applicant appears to meet this criterion.*

- b. **The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.**

*The applicant projects 8,921 patient days of care in Year 1 of the project and 9,516 patient days of care in Year 2 of the project.*

**Princeton Transitional Care**

**CN1409-039**

**November 19, 2014**

**PAGE 2**

*It appears this criterion has been met.*

**3. For renovation or expansions of an existing licensed health care institution:**

- a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**

*Not applicable to this application.*

- b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

*Not applicable to this application.*

**STAFF SUMMARY**

***Note to Agency members: This staff summary is a synopsis of the original application and supplemental responses submitted by the applicant. Any HSDA Staff comments will be presented as a "Note to Agency members" in bold italics.***

**Summary**

Princeton Transitional Care, working with its owner, Mountain States Health Alliance (MSHA), seeks to enhance the continuity of care for the elderly and improve operational efficiencies for both skilled nursing care and inpatient rehabilitation through partnerships with HealthSouth Corporation and Signature HealthCARE. The joint venture partnerships will expand service offerings at Quillen Rehabilitation Hospital (QRH) and develop a new elder care community that will include skilled nursing care services. The new elder care community will involve the ultimate relocation of the 34 skilled nursing bed Princeton Transitional Care and 13 skilled nursing bed Franklin Transitional Care (inactive status) from Johnson City Medical Center. The construction of the new eldercare community will take 18-24 months. The new elder care community will be built on the former site of North Side Hospital (owned by MSHA) located at 401 Princeton Road, Johnson City (Washington County).

JCMC has agreed to house Princeton Transitional Care's 34 skilled nursing care beds during the construction of the new elder care campus (an additional CON will be filed later). The following is the interim plan that includes the temporary relocation of the existing and operational Princeton 34 bed nursing unit:

**Princeton Transitional Care**

**CN1409-039**

**November 19, 2014**

**PAGE 3**

- The 13,100 SF of vacated space left at QRH by Princeton Transitional Care unit will allow HealthSouth to make the necessary upgrades and adjustments to the physical space to modernize the inpatient rehabilitation area.
- HealthSouth plans to convert many of the semi-private rooms in the QRH vacated space to private rooms for inpatient rehabilitation services.
- Franklin Transitional Care (FTC) is currently located at Johnson City Medical Center but is in inactive status.
- If approved, Signature HealthCARE will manage the 34-bed PTC skilled nursing unit within JCMC as the elder care campus is being constructed.
- Once the new elder care community is complete, both PTC (34 beds) and FTC (13 beds) will relocate their combined 47 beds to the new campus.

### **Ownership Information**

Princeton Transitional Care is a satellite facility of Johnson City Medical Center, a 658 licensed bed regional tertiary hospital owned by Mountain States Health Alliance. The not-for-profit Mountain States Health Alliance health system includes 14 hospitals. An organizational structure consisting of facilities owned by Mountain States Health Alliance is located in Attachment A.4.

### **Facility Information**

- The existing 13,100 SF 34 bed skilled nursing unit located at QRH will relocate to 14,334 SF of existing space on the 3rd floor of Johnson City Medical Center.
- The new proposed location for the 34 bed skilled nursing unit at JCMC previously housed skilled nursing beds (FTC) and is still equipped for those services.
- The project involves minor renovations to the hospital space such as patching and minor renovations to the day room to ensure compliance with current codes.
- The bed complement of PTC will consist of 34 private beds.
- Floor plan drawings are included in Attachment B.IV.

Johnson City Medical Center consists of its main campus and two satellite campuses: Woodridge Hospital (behavioral health services) and QRH for a total of 658 licensed beds. As the arrow indicates in the following table, the 34 skilled nursing beds located at the Princeton Transitional Nursing Home on the Quillen campus will relocate to the Johnson City main campus if this project is approved. The total number of beds at JCMC will remain unchanged.

**Princeton Transitional Care**

**CN1409-039**

**November 19, 2014**

**PAGE 4**

### Johnson City Medical Center Current and Proposed Bed Complement

	Current Bed Complement	Proposed Bed Complement
Main Campus	501 Acute Care Beds	501 Acute Care Beds
	*13 Franklin Transitional Beds (inactive status)	*13 Franklin Transitional Beds (inactive status)
		<b>Relocate: 34 Princeton Transitional Care SNF Beds</b>
Woodridge Campus	84 Psychiatric Beds	84 Psychiatric Beds
Quillen Campus	26 Rehabilitation Beds	26 Rehabilitation Beds
	<b>34 Princeton Transitional Care Beds</b>	-----
<b>Total JCMC</b>	<b>658 Beds</b>	<b>658 Beds</b>

Source: CN1409-039

*\*On September 10, 2014, Franklin Transitional Care was approved by the Department of Health for its license to be placed on inactive status as MSHA and Signature HealthCARE develop an elder care campus that will include a continuum of care. Once the campus is opened (June 2016 target), the intent is to reactivate FTC's license and operate those beds on the new campus (a CON will have to be obtained).*

#### Project Need:

- Approval of this application will enable the temporary relocation of Princeton Transitional Care to JCMC, which will enable HealthSouth to proceed with plans to improve the QRH facility infrastructure and expand clinic programmatic space to better meet the needs of the inpatient rehabilitation patient population.

**Princeton Transitional Care**

**CN1409-039**

**November 19, 2014**

**PAGE 5**

- The temporary relocation of PTC will ensure the continuity of hospital-based skilled nursing services while the permanent location is being built on the pending MSHA/Signature HealthCare elder care campus.

#### **Service Area Demographics:**

Johnson City Medical Center's declared service area consists of Carter, Greene, Johnson, Unicoi, Sullivan, and Washington counties.

- The total population of 6 county service area is expected to increase by 2.6% from 453,502 residents in 2014 to 465,418 residents in 2016.
- The overall statewide population is projected to grow by 1.8% from 2014 to 2016.
- The service area 2014 age 65 and older category will increase by approximately 5.1% from 87,614 residents in 2014 to 92,120 in 2016 compared to a statewide increase of 6.1%.
- The 65 and older population cohort presently accounts for approximately 19.3% of the total service population compared to a statewide average of 14.9%.
- The number of service area residents enrolled in the TennCare program is estimated at approximately 16.9% of the service area population compared with the statewide average of 18.8%.

#### **Historical and Projected Utilization**

The licensed bed occupancy of the 5 service area hospital-based skilled nursing homes was approximately 85% in calendar year 2012. Key highlights follow:

	County	Licensed Beds	2012 Patient Days			2012 Occupancy
			Non-Skilled	Skilled	Total	
Indian Path Medical Center	Sullivan	22	0	5,917	5,917	73.7%
Franklin Transitional Care	Washington	13	0	3,571	3,571	75.2%
Laughlin Healthcare Center	Greene	90	21,578	7,313	28,891	87.9%
Princeton Transitional Care	Washington	34	0	8,622	8,622	69.5%
Unicoi County Nursing Home	Unicoi	46	13,738	2,836	16,574	98.7%
Total		205	35,316	28,259	63,575	85%

Source: 2012 Joint Annual Report

- Laughlin Healthcare Center and Unicoi County Nursing Home provide more non-skilled services than skilled nursing services.
- Overall, non-skilled care represented 55% of patient days in hospital based skilled nursing units in 2012.

#### Princeton Transitional Care Historical and Projected Utilization

	2010	2011	2012	2013		2016	2017
Admissions	889	705	692	706		805	859
Patient Days	11,131	10,173	8,622	8,950		8,921	9,516
ALOS	12.5	14.4	12.5	12.7		11.1	11.1
Licensed Beds	34	34	34	34		34	34
Occupancy	89.7%	81.9%	69.5%	72.1%		71.9%	76.7%

The utilization table above reflects the following:

- Admissions in 2017 will decrease 3.3% from 889 in 2010 to 859 in 2017 (Year 2).
- The occupancy of Princeton Transitional Care was trending downward from 81.9% in 2011 to 72.1% in 2013, but is projected to

slightly recover from 71.9% in Year 1 to 76.7% in Year 2 of the proposed project.

The table below highlights the projected utilization in the first two years of the project.

**Princeton Transitional Care Projected Utilization**

Year	Licensed Beds	Dually certified beds	SNF Medicare ADC	SNF Medicaid ADC	Skilled Other payors ADC	Non Skilled ADC	Total ADC	Occup.
2016	34	34	16.2	0	8.2	n/a	24.4	71.9%
2017	34	34	17.3	0	8.8	n/a	26.1	76.7%

*Source: Supplemental response, Page 6*

- Princeton Transitional Care estimates the licensed occupancy of the 34-bed nursing unit will increase from 71.9% in 2016 to 76.7% in 2017.
- The applicant projects a patient mix of 16.2 Medicare skilled patients and 8.2 skilled (other payors) for a total average daily census of approximately 24.4 patients per day in the first year of the project.

### **Project Cost**

Major costs of the \$21,000 total estimated project cost are:

- Renovation (including contingency) - \$14,500 or 69% of total cost.

For other details on Project Cost, see the Project Cost Chart on page 26 of the original application. The applicant expects that the proposed project will involve only minor refurbishments (patching and painting) and minor renovations to the day room to ensure compliance with current codes.

A letter dated September 14, 2014 from SHC Construction Services states that the proposed construction costs are reasonable and that the plan will have all the requisite elements required by the 2010 AIA Guidelines for the Design and Construction of Healthcare Facilities as well as the Americans with Disabilities Act Accessibility Guidelines.

The applicant expects to renovate 14,334 square feet at a cost under a \$1.00 per square foot.

### **Historical Data Chart**

The applicant provided a Historical Data Chart for Johnson City Medical Center.

**Princeton Transitional Care**

**CN1409-039**

**November 19, 2014**

**PAGE 8**

- Johnson City Medical Center reported net operating income after capital expenditures of \$50,839,828 in FY2012, \$29,298,637 in FY2013, and \$29,757,103 in FY2014.

### **Projected Data Chart**

The applicant provided a Projected Data Chart for the 34-bed Princeton Transitional Care Unit day). The Projected Data Chart reflects the following:

- In FY2016 on projected 8,921 patient days, gross operating revenue is projected to be \$22,033,086 (\$2,469.80/day) and in FY2017 on 9,516 patient days, projected gross operating revenue is \$23,502,617 (\$2,469.80/day).
- Deductions from operating revenue are projected to total \$18,328,729 in FY2016 or 83.2% of gross revenue and in FY2017 total deductions of \$19,537,055 or 83.1% of gross revenues.
- With net operating revenue in 2017 of \$3,704,357 and operating expenses of \$3,846,124, the result is a projected net operating loss of (\$141,767). Net operating loss is expected to decline to (\$137,750) in FY2017.
- In the first supplemental response, the applicant indicated that the expectation is PTC will break even in Year 3 when it is part of the new elder care campus.
- Charity care is projected to be \$740,563 in FY2016 or approximately 3.4% of gross revenues reflecting approximately 300 patient days and in FY2017 the projected charity care of \$792,783 or 3.4% of gross operating revenue reflecting approximately 321 patient days.

### **Charges**

Summarizing from the revised Projected Data Chart the average patient daily charges are as follows:

- The proposed average gross per diem charge is \$2,469.80/day in FY2016; however, the net charge after contractual adjustments amounts to \$415.24 per day. Net charges increase to \$416.73 in FY2017.

***Note to Agency Members: Section 4432(a) of the Balanced Budget Act of 1997 changed how payment is made for Medicare skilled nursing facility services from a cost based to a per-diem prospective payment system (PPS) covering all costs (routine, ancillary and capital) related to the services furnished to beneficiaries under Part A of the Medicare program. Under PPS, payments for each admission are case-mix adjusted to classify residents into a Resource Utilization Group (RUG) category based on data from resident assessments and relative weights developed from staff time data. Source: "Skilled Nursing Facility PPS", CMS.gov.***

**Princeton Transitional Care**

**CN1409-039**

**November 19, 2014**

**PAGE 9**

**Medicare/TennCare Payor Mix**

- Medicare and Managed Medicare- In FY2016 gross revenue of \$15,554,502 or approximately 70% of total revenue.
- TennCare/Medicaid - In FY2016 gross revenue of \$1,525,051 or approximately 7% of total revenue.

**Financing**

A 9/10/14 letter from Lynn Krutak, Senior Vice President/CFO, Mountain States Health Alliance certifies that existing cash reserves will be used for the proposed project.

Review of Mountain States Health Alliance's audited financial statements prepared by Pershing Yoakley & Associates, P.C. for the period ending June 30, 2013 indicates \$74,902,000 in cash and cash equivalents, total current assets of \$324,016,000, total current liabilities of \$238,865,000 and a current ratio of 1.36 to 1.

*Note to Agency members: current ratio is a measure of liquidity and is the ratio of current assets to current liabilities, which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.*

**Staffing**

The applicant's current staffing pattern for Princeton Transitional Care totals to direct patient care staffing of 26.1 full time equivalents (FTE), direct patient care staff calculates to approximately 6.14 hours of care per resident per day. Clinical staff includes the following positions classifications:

- 2.0 FTE Speech/Language Therapist
- 10.5 FTE Registered Nurses (RNs)
- 4.2 FTE Licensed Practical Nurses (LPN)
- 8.4 FTE Patient Care Partner
- 1.0 FTE Activities Coordinator

*Note to Agency Members: 1 FTE means an employee who works 2,080 regular hours per year. Current licensure standards require nursing homes to have adequate numbers of licensed registered nurses, licensed practical nurses and certified nurse aides to provide nursing care to all residents as needed. Nursing homes shall provide a minimum of 2 hours of direct care to each resident every*

**Princeton Transitional Care**

**CN1409-039**

**November 19, 2014**

**PAGE 10**

*day including 0.4 hours of licensed nursing personnel time. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the availability of a licensed nurse for bedside care of any resident. Source: Chapter 1200-08-06-.06, Rules of the Board for Licensing Health Care Facilities, Division of Health Care Facilities, Tennessee Department of Health (revised March 2014).*

#### **Licensure/Accreditation**

Princeton Transitional Care is licensed by the Tennessee Department of Health and certified by Medicare and Medicaid.

*Corporate and property documentation are on file at the Agency office and will be available at the Agency meeting.*

Should the Agency vote to approve this project, the CON would expire in **two** years. The applicant expects to initiate the service in Johnson City Medical Center during February 2015.

#### **CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT**

There are no other Letters of Intent, denied or pending applications for this applicant.

#### **Outstanding Certificates of Need**

**Johnson City Medical Center, CN1106-021A**, has an outstanding Certificate of Need, which will expire on May 1, 2015. It was approved at the September 28, 2011 meeting for the renovation and expansion of the current radiation oncology department in the existing main campus structure of JCMC. The estimated project cost is **\$14,999,924**. *Project Status Update: This CON was originally scheduled to expire on November 1, 2014. A six-month extension was granted at the Agency's June 2014 meeting. A representative of the applicant indicated by an 11/7/14 email that the linear accelerator equipment purchase has been completed and is in the process of installation. The installation includes several weeks for calibration studies and anticipates the first patient will be treated in February. The project is on schedule and within the CON approved budget.*

**Princeton Transitional Care**

**CN1409-039**

**November 19, 2014**

**PAGE 11**

**CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:**

There are no Letters of Intent, denied applications, or pending applications for other health care organizations in the service area proposing this type of service.

**Outstanding Certificates of Need**

**Cristian Care Center of Bristol, CN1404-012A**, has an outstanding certificate of need that will expire on September 1, 2016. The CON was approved at the July 23, 2014 Agency meeting. Christian Care Center of Bristol is a 120-bed inactive nursing home located at 261 North Street, Bristol (Sullivan County), Tennessee. The CON was approved to relocate and construct a replacement facility approximately 8 miles from the current site to an unimproved lot located at 2830 Highway 394, Bristol (Sullivan County), TN. The project is not subject to the 125-bed Nursing Home Bed Pool for the 2013-2014 state fiscal years because no new beds are being added. The estimated project cost is **\$11,953,747.00**. *Project Status: This project was recently approved.*

**NHC at Indian Path, LLC, CN1212-059A**, has an outstanding certificate of need that will expire on July 1, 2015. The CON was approved at the May 22, 2013 Agency meeting for the replacement and relocation of the 22 bed Indian Path Medical Center Transitional Care Unit and the addition of 30 new Medicare certified skilled nursing home beds. The facility will relocate from Indian Path Medical Center at 2000 Brookside Drive to 2300 Pavilion Drive, Kingsport (Sullivan County), TN. The new facility will be licensed as NHC at Indian Path and will contain 52 Medicare-only (skilled) nursing home beds. The estimated project cost is **\$10,385,615.00**. *Project Status: A representative of the applicant indicated by telephone on 11/7/14 that a certificate of occupancy was granted in October 2014 and that life safety and licensure surveys are scheduled for November 2014.*

**PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.**

*PME/MAF (11/7/14)*

**Princeton Transitional Care  
CN1409-039  
November 19, 2014  
PAGE 12**

## **LETTER OF INTENT**



## LETTER OF INTENT TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Johnson City Press which is a newspaper  
(Name of Newspaper)  
of general circulation in Washington County, Tennessee, on or before September 10, 2014,  
(County) (Month / day) (Year)  
for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: Johnson City Medical Center, an existing hospital provider  
(Name of Applicant) (Facility Type-Existing)

owned by: Mountain States Health Alliance with an ownership type of Not-for-Profit Corporation  
and to be managed by: self intends to file an application for a Certificate of Need  
for the relocation Princeton Transitional Care's thirty-four (34) Skilled Nursing Facility beds from James H. and Cecile C. Quillen Rehabilitation Hospital at 2511 Wesley Street, Johnson City, TN 37601 to Johnson City Medical Center at 400 North State of Franklin Road, Johnson City, TN, 37604. No new services will be initiated and no major medical equipment will be purchased. There will be no change in Princeton Transitional Care's or Johnson City Medical Center's licensed bed complement. The estimated project cost is \$21,000.

The anticipated date of filing the application is: September 15, 2014

The contact person for this project is Allison Rogers Vice-President, Strategic Planning  
(Contact Name) (Title)

who may be reached at: Mountain States Health Alliance 303 Med Tech Parkway, Suite 330  
(Company Name) (Address)

Johnson City TN 37604 423/302-3378  
(City) (State) (Zip Code) (Area Code / Phone Number)

Allison M. Rogers 9/9/14 RogersAM@msha.com  
(Signature) (Date) (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency  
Andrew Jackson Building  
500 Deaderick Street, Suite 850  
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

# **ORIGINAL APPLICATION**

# **MOUNTAIN STATES HEALTH ALLIANCE**

Princeton Transitional Care Relocation Project

*Certificate of Need Application  
September 15<sup>th</sup>, 2014*

Prepared for:  
Tennessee Health Services and Development Agency  
Andrew Jackson Building, Ninth Floor  
502 Deaderick Street Nashville, TN 37243  
615.741.2364

Contact:  
Allison Rogers  
423.302.3378

**APPLICANT PROFILE**

Please enter all Section A responses on this form. All questions must be answered. If an item does not apply, please indicate "N/A". **Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment.**

**For Section A, Item 1, Facility Name must be applicant facility's name and address must be the site of the proposed project.**

**For Section A, Item 3, Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence, if applicable, from the Tennessee Secretary of State.**

**For Section A, Item 4, Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% or more ownership interest. In addition, please document the financial interest of the applicant, and the applicant's parent company/owner in any other health care institution as defined in Tennessee Code Annotated, §68-11-1602 in Tennessee. At a minimum, please provide the name, address, current status of licensure/certification, and percentage of ownership for each health care institution identified.**

**For Section A, Item 5, For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.**

Please describe the management entity's experience in providing management services for the type of the facility, which is the same or similar to the applicant facility. Please describe the ownership structure of the management entity.

**For Section A, Item 6, For applicants or applicant's parent company/owner that currently own the building/land for the project location; attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.**

<b>1. <u>Name of Facility, Agency, or Institution</u><sup>21</sup></b>			
Johnson City Medical Center Name			
400 North State of Franklin Road Street or Route		Washington County	
Johnson City City	TN State	37604 Zip Code	
<b>2. <u>Contact Person Available for Responses to Questions</u></b>			
Allison Rogers Name		VP, Strategic Planning Title	
Mountain States Health Alliance Company Name		RogersAM@msha.com Email address	
303 Med Tech Parkway, Suite #330 Street or Route		Johnson City City	TN State
		37604 Zip Code	
Employee Association with Owner		423.302.3378 Phone Number	423.302.3448 Fax Number
<b>3. <u>Owner of the Facility, Agency or Institution</u></b>			
Mountain States Health Alliance Name		423-431-6111 Phone Number	
303 Med Tech Parkway, Suite #330 Street or Route		Washington County	
Johnson City City	TN State	37604 Zip Code	
<b>4. <u>Type of Ownership of Control (Check One)</u></b>			
A. Sole Proprietorship _____	F. Government (State of TN or Political Subdivision) _____		
B. Partnership _____	G. Joint Venture _____		
C. Limited Partnership _____	H. Limited Liability Company _____		
D. Corporation (For Profit) _____	I. Other (Specify) _____		
E. Corporation (Not-for-Profit) <u>  X  </u>			

**PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.**

5. **Name of Management/Operating Entity (If Applicable)**

**September 29, 2014  
10:30 am**

Signature HealthCARE, LLC  
Name

12201 Bluegrass Parkway

Street or Route

County

Louisville

Kentucky

40299

City

State

Zip Code

**PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND  
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.**

6. **Legal Interest in the Site of the Institution (Check One)**

- |                                 |               |                    |               |
|---------------------------------|---------------|--------------------|---------------|
| A. Ownership                    | <u>  X  </u>  | D. Option to Lease | <u>      </u> |
| B. Option to Purchase           | <u>      </u> | E. Other (Specify) | <u>      </u> |
| C. Lease of <u>      </u> Years | <u>      </u> |                    |               |

**PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND  
REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.**

7. **Type of Institution (Check as appropriate--more than one response may apply)**

- |  |               |  |               |
|--|---------------|--|---------------|
| A. Hospital (Specify)  | <u>      </u> | I. Nursing Home                        | <u>  X  </u>  |
| B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty    | <u>      </u> | J. Outpatient Diagnostic Center        | <u>      </u> |
| C. ASTC, Single Specialty  | <u>      </u> | K. Recuperation Center                 | <u>      </u> |
| D. Home Health Agency  | <u>      </u> | L. Rehabilitation Facility             | <u>      </u> |
| E. Hospice   | <u>      </u> | M. Residential Hospice                 | <u>      </u> |
| F. Mental Health Hospital  | <u>      </u> | N. Non-Residential Methadone Facility  | <u>      </u> |
| G. Mental Health Residential Treatment Facility                    | <u>      </u> | O. Birthing Center                     | <u>      </u> |
| H. Mental Retardation Institutional Habilitation Facility (ICF/MR) | <u>      </u> | P. Other Outpatient Facility (Specify) | <u>      </u> |
|  |               | Q. Other (Specify)                     | <u>      </u> |

8. **Purpose of Review (Check) as appropriate--more than one response may apply)**

- |  |               |   |               |
|--|---------------|---|---------------|
| A. New Institution   | <u>      </u> | G. Change in Bed Complement   |               |
| B. Replacement/Existing Facility   | <u>      </u> | [Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation] |               |
| C. Modification/Existing Facility  | <u>      </u> |   |               |
| D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) | <u>      </u> | H. Change of Location   | <u>  X  </u>  |
| E. Discontinuance of OB Services   | <u>      </u> | I. Other (Specify)  | <u>      </u> |
| F. Acquisition of Equipment  | <u>      </u> |   |               |

9. **Bed Complement Data –** 23  
**Please indicate current and proposed distribution and certification of facility beds<sup>1</sup>.**

Note: Licensure for Johnson City Medical Center (JCMC) includes Quillen Rehabilitation Hospital and Woodridge Psychiatric Hospital.

<sup>1</sup> Includes Franklin Transitional Care (13 SNF beds) and Princeton Transitional Care (34 SNF beds).

	<u>Current Beds Licensed *CON</u>	<u>Staffed Beds</u>	<u>Beds Proposed</u>	<u>TOTAL Beds at Completion</u>
A. Medical	<u>361</u>	<u>346</u>	<u>      </u>	<u>361</u>
B. Surgical (included above in medical)	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
C. Long-Term Care Hospital	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
D. Obstetrical	<u>21</u>	<u>21</u>	<u>      </u>	<u>21</u>
E. ICU/CCU	<u>60</u>	<u>60</u>	<u>      </u>	<u>60</u>
F. Neonatal	<u>39</u>	<u>39</u>	<u>      </u>	<u>39</u>
G. Pediatric	<u>20</u>	<u>20</u>	<u>      </u>	<u>20</u>
H. Adult Psychiatric (Woodridge Psychiatric Hospital)	<u>84</u>	<u>84</u>	<u>      </u>	<u>84</u>
I. Geriatric Psychiatric (included above in WPH)	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
J. Child/Adolescent Psychiatric (included above)	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
K. Rehabilitation (Quillen Rehabilitation Hospital)	<u>26</u>	<u>26</u>	<u>      </u>	<u>26</u>
L. Nursing Facility (non-Medicaid Certified)	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
M. Nursing Facility Level 1 (Medicaid only)	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
N. Nursing Facility Level 2 (Medicare only)	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
O. Nursing Facility Level 2 (dually certified Medicaid/Medicare) <sup>1</sup>	<u>47</u>	<u>34</u>	<u>      </u>	<u>47</u>
P. ICF/MR	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
Q. Adult Chemical Dependency	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
R. Child and Adolescent Chemical Dependency	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
S. Swing Beds	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
T. Mental Health Residential Treatment	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
U. Residential Hospice	<u>      </u>	<u>      </u>	<u>      </u>	<u>      </u>
<b>TOTAL</b>	<b><u>658</u></b>	<b><u>630</u></b>	<u>      </u>	<b><u>658</u></b>

10. Medicare Provider Number 44-5356  
Certification Type Skilled Nursing Facility

11. Medicaid Provider Number 04-45356  
Certification Type Skilled Nursing Facility

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid? N/A

13. **Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area. Will this project involve the treatment of TennCare participants? Yes If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted or plans to contract. Discuss any out-of-network relationships in place with MCOs/BHOs in the area.**

**RESPONSE (QUESTION 13):**

This project will continue to involve the treatment of TennCare participants. Princeton Transitional Care is a participant in the following MCOs:

Americhoice (United Healthcare)

BlueCare (BlueCross)

In addition to the aforementioned MCOs, Johnson City Medical Center is also a participant in the following BHOs:

UBH

ValueOptions

**NOTE:** **Section B** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. **Section C** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

## **SECTION B: PROJECT DESCRIPTION**

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

- I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.**

### **RESPONSE:**

This application is for approval by the Health Services and Development Agency to relocate existing skilled nursing beds within Washington County, TN. Princeton Transitional Care (PTC) is a 34-bed skilled nursing unit currently located at James H. and Cecile C. Quillen Rehabilitation Hospital (2511 Wesley Street, Johnson City, TN, referred to as "Quillen"). Quillen is currently a satellite of facility of Johnson City Medical Center. The proposed project seeks approval to relocate the 34-bed SNF unit to Johnson City Medical Center (400 N. State of Franklin Road, Johnson City, TN). These 34 skilled nursing beds will occupy 14,334 square feet of existing space at JCMC. The estimated project cost is \$21,000. Funding for this project will be through the use of existing cash reserves of Mountain States Health Alliance (MSHA).

The project stems from the opportunity to expand the post-acute care continuum available in the Washington County market. MSHA has identified two partners who will bring significant resources and expertise to the provision of post-acute care services in the community and elevate the quality and continuity of care provided locally. First, MSHA will be partnering with HealthSouth Corporation to enhance the provision of inpatient rehabilitation services. Currently James H. and Cecile C. Quillen Rehabilitation Hospital is a 60-bed facility licensed under Johnson City Medical Center (JCMC), and houses 26 licensed inpatient rehabilitation beds as well as the 34 licensed skilled nursing beds of PTC. The long-term intention of the MSHA/HealthSouth joint venture is to expand the availability of inpatient rehabilitation beds at QRH. Improvements and expansion of QRH that require a certificate of need will be addressed in an application filed at a later date after plans have been finalized. In the meantime HealthSouth will be expanding clinical programs and converting many of the semi-private rooms currently in place to private rooms. Given the lack of unused space within the building, this necessitates the request to relocate PTC from QRH to JCMC.

Second, MSHA will be partnering with Signature HealthCARE to enhance the provision of skilled nursing facility care within Washington County. Currently MSHA has two licensed skilled nursing facilities within Washington County: Princeton Transitional Care (34 beds) and Franklin Transitional Care (13 beds). MSHA has struggled over the years to maximize the effectiveness of these two units, and as such, decided to seek an external partner with

expertise in this area. The long-term intention of this partnership is to develop an elder care campus which will provide a continuum of care for the older population – including skilled nursing care, assisted living, and retirement living options. This will be constructed on the old North Side Hospital campus (which MSHA also owns) located at 401 Princeton Road, Johnson City, TN. Both entities recognize a separate Certificate of Need will be needed to relocate the two SNF units and an application will be filed at a later date. In the meantime, Signature HealthCARE will manage the PTC unit at its proposed location within JCMC. A letter from Signature regarding the management agreement is provided in Attachment B.I. This will ensure that MSHA can continue to provide this vital service to the community as these partnerships put their plans into action which will lead to an overall enhancement of post- acute care services in Washington County.

Because HealthSouth will be making some capital improvements to QRH to expand clinical programming space and convert many of the semi-private rooms to private, they will need to utilize some of the space that PTC is currently occupying. So this request is to relocate PTC to JCMC temporarily where it will be managed by Signature as the elder care campus is being constructed. Once the campus is complete, Signature will seek to relocate both PTC (34 SNF beds) and FTC (13 SNF beds) to that site which will also house assisted living and retirement community services.

Johnson City Medical Center is the regional, tertiary hospital for Mountain States Health Alliance, a large, integrated, not-for-profit health care system. Founded in 1998, MSHA has historical community roots in the Johnson City Medical Center (JCMC) (1980-Present), Memorial Hospital (1951-1980), and Appalachian Hospital (1911-1951). The hospital system includes fourteen hospitals providing a core of acute care, hospital-based services, and an array of supporting services. In addition, MSHA operates urgent care centers, outpatient facilities, laboratory and radiology services, physician practices, long-term care and rehabilitation facilities, and community-based prevention and educational activities to a population of over 1.1 million residents of southern and central Appalachia. The twenty-nine (29) county service area consists of counties from Tennessee, Virginia, Kentucky and North Carolina.

The proposed project will not add any additional acute care, rehabilitation or skilled nursing beds to the service area. This proposal will allow MSHA to maximize its existing complement of licensed beds in Washington County to appropriately align full complement of services needed to meet the changing needs of the service area population across the continuum of care.

**II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.**

- A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of \$5 million) and other facility projects (construction cost in excess of \$2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed**

square footage. The total cost per square foot should be provided, broken out between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

The proposed project involves the relocation of a 34-bed skilled nursing unit, Princeton Transitional Care, from James H. and Cecile C. Quillen Rehabilitation Hospital to Johnson City Medical Center. The proposed location is on the third floor of JCMC. There are currently two nursing units, 3200 and 3300, which would be designated skilled nursing facility space. This area previously housed skilled nursing beds (Franklin Transitional Care) so the area already contains a distinguishable barrier between the skilled nursing unit and rest of the acute care hospital. This project only involves minor refurbishments (patching and painting) and minor renovations to the day room to ensure compliance with current regulatory statutes.

The minor refurbishments to the facility would not require temporary relocation for any patients due to the currently lower census of Johnson City Medical Center.

The proposed project will not initiate any new services or addition of major medical equipment (as defined by T.C.A. § 68-11-1601 et seq.) and will cost \$21,000. The total construction cost will be minimal at \$10,500 or \$0.73 a square foot.

**B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.**

There will be no change in the total number of beds within Washington County. This request is to relocate 34 SNF beds from their current location within QRH to JCMC.

	Current Bed Complement	Proposed Bed Complement
<b>Johnson City Medical Center</b>		
<i>Main Campus</i>	501 Acute Care Beds 13 FTC SNF Beds*	501 Acute Care Beds 13 FTC SNF Beds** <b>RELOCATE: 34 PTC SNF Beds</b>
<i>Woodridge Campus</i>	84 Psychiatric Beds	84 Psychiatric Beds
<i>Quillen Campus</i>	26 Rehabilitation Beds 34 PTC SNF Beds	26 Rehabilitation Beds -----
<i>Total JCMC</i>	658 Beds	658 Beds
<b>Franklin Woods Community Hospital</b>		
	80 Acute Care Beds	80 Acute Care Beds
<b>Total Washington County Beds</b>		
	738 Beds	738 Beds

\*currently suspended

\*\*continue to suspend

## 28

Revised Page 10

**C. As the applicant, describe your need to provide the following health care services (if applicable to this application):**

1. **Adult Psychiatric Services**
2. **Alcohol and Drug Treatment for Adolescents (exceeding 28 days)**
3. **Birthing Center**
4. **Burn Units**
5. **Cardiac Catheterization Services**
6. **Child and Adolescent Psychiatric Services**
7. **Extracorporeal Lithotripsy**
8. **Home Health Services**
9. **Hospice Services**
10. **Residential Hospice**
11. **ICF/MR Services**
12. **Long-term Care Services**
13. **Magnetic Resonance Imaging (MRI)**
14. **Mental Health Residential Treatment**
15. **Neonatal Intensive Care Unit**
16. **Non-Residential Methadone Treatment Centers**
17. **Open Heart Surgery**
18. **Positron Emission Tomography**
19. **Radiation Therapy/Linear Accelerator**
20. **Rehabilitation Services**
21. **Swing Beds**

Not applicable

**D. Describe the need to change location or replace an existing facility.**

The proposed project addresses a major concern for Mountain States Health Alliance which has been the effectiveness of post-acute care resources in Washington County. Given the changing healthcare landscape and the vital role that post-acute care has in effective population health management, it was critical for MSHA to reorganize this service offering. MSHA seeks to enhance continuity of care and improve operational efficiency for both skilled nursing care and inpatient rehabilitation in Washington County through select partnerships with HealthSouth Corporation and Signature HealthCARE. Both organizations have significant resources and expertise within their respective areas of focus and MSHA has developed partnerships with both entities to leverage their capabilities to improve the post-acute arena within Washington County.

Mountain States has entered into a definitive agreement with HealthSouth Corporation to create a joint venture partnership that will expand service offerings at Quillen Rehabilitation Hospital. This will require renovation and expansion of clinical programming space at QRH; however, the existing space is maximized with the presence of Princeton Transitional Care's 34 beds. This necessitates a need to reconsider the location of the 34 SNF beds. At the same time, MSHA has separately signed a letter of intent with Signature HealthCARE to develop a new patient- and family-friendly elder care community that will include skilled nursing care services among others (retirement living and assisted living). This will involve the ultimate relocation of MSHA's 47 skilled nursing care beds (34 at PTC and 13 at FTC) to this new community campus; however, this will require 18 to 24 months

of construction (and an additional CON which will be filed at a later date). In the meantime, both Signature HealthCARE and MSHA feel it is essential for the community to have continued access to these existing SNF services. As such, JCMC has agreed to give up space within its facility to temporarily house PTC's 34 skilled nursing care beds as this new campus is being constructed.

As a result of these partnerships, it is necessary to develop an interim plan to temporarily relocate the existing and operational 34-bed skilled nursing unit, Princeton Transitional Care. The project application requests the relocation of the 34-bed skilled nursing unit (PTC), from the campus of Quillen Rehabilitation Hospital to Johnson City Medical Center. This will free up space for HealthSouth to make the necessary upgrades and adjustments to the physical space within QRH needed to elevate and modernize the inpatient rehabilitation patient experience. Additionally Signature HealthCARE will manage the unit within JCMC as the elder care campus is constructed at the old North Side Hospital location (401 Princeton Road, Johnson City). The intent is to demolish that building and construct a complete elder care campus with offerings including retirement community living, assisted living facility, and skilled nursing care.

**E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of \$1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:**

**1. For fixed-site major medical equipment (not replacing existing equipment):**

**a. Describe the new equipment, including:**

- 1. Total cost; (As defined by Agency Rule).**
- 2. Expected useful life;**
- 3. List of clinical applications to be provided; and**
- 4. Documentation of FDA approval.**

**b. Provide current and proposed schedules of operations.**

Not applicable

**2. For major mobile medical equipment:**

- a. List all sites that will be served;**
- b. Provide current and/or proposed schedule of operations;**
- c. Provide the lease or contract cost;**
- d. Provide the fair market value of the equipment; and**
- e. List the owner for the equipment.**

Not applicable

**3. Indicate applicant's legal interest in equipment (i.e., purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.**

Not applicable

**III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:**

- 1. Size of site (in acres);**
- 2. Location of structure on the site; and**
- 3. Location of the proposed construction.**
- 4. Names of streets, roads or highway that cross or border the site.**

***Please note that all drawings do not need to be drawn to scale. Plot plans are required for all projects.***

Princeton Transitional Care, a 34-bed skilled nursing facility, will be relocated to Johnson City Medical Center, 400 North State of Franklin Road, Johnson City, Tennessee. Included in Attachment B.III.(A) is the plot plan for Johnson City Medical Center. The 34 skilled nursing beds will be relocated to a 14,334 square foot unit located within Johnson City Medical Center. The size of the JCMC campus is 54.167 acres.

**(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.**

Johnson City Medical Center is located at 400 N. State of Franklin Road (State 321) on the corner of Highway 11E in Johnson City, Tennessee and is accessible from Interstate 26. Johnson City Medical Center is a stop on the Johnson City Transit Public Transportation service. The proposed site is accessible through multiple access points for ambulatory patients, patients transferred into the facility and for emergent patients. JCMC has a helicopter service available for emergent and inter-facility transfers.

**IV. Attach a floor plan drawing for the facility, which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.**

**NOTE: DO NOT SUBMIT BLUEPRINTS. Simple line drawings should be submitted and need not be drawn to scale.**

Floor plans for the project are provided in Attachment B.IV.

**V. For a Home Health Agency or Hospice, identify:**

- 1. Existing service area by County;**
- 2. Proposed service area by County;**
- 3. A parent or primary service provider;**
- 4. Existing branches; and**
- 5. Proposed branches.**

Not Applicable

## **SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED**

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. Please type each question and its response on an 8 1/2" x 11" white paper. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

### **QUESTIONS**

#### **NEED**

**1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.**

- a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

**Special Criteria for Construction, Renovation, Expansion, and Replacement of Health Care Institutions**

**1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.**

This project does not involve the addition of beds, services or major medical equipment, but better fits the description for the relocation and renovation of an existing health care institution and is addressed in the following sections for 2 (a), 2 (b), 3 (a) and 3 (b).

**2. For relocation or replacement of an existing licensed health care institution:**

- a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

This project involves the relocation of the existing 34 skilled nursing beds from their current location at Quillen Rehabilitation Hospital into renovated space within Johnson City Medical Center. By relocating these beds, HealthSouth can proceed with plans to improve the facility infrastructure at QRH and expand the clinical space programming to enhance care for the inpatient rehabilitation population. Also, the temporary relocation of PTC to JCMC will ensure the continued provision of this much needed service while MSHA and Signature HealthCare complete plans to construct a comprehensive eldercare campus in Johnson City. The strength of this project is that it will enhance the

overall provision of post-acute care services in Washington County at a minimal project cost of \$21,000.

One disadvantage with this approach will be the impact to JCMC's existing bed capacity. While this may prove challenging during peak census, JCMC is confident with existing resources at Franklin Woods Community Hospital (80 beds, also in Washington County), this challenge can be proactively managed. In fact, immediate access to the 34-SNF beds within JCMC will provide an opportunity to lower the length of stay on the acute care side as well thus improving JCMC's ability to manage any potential temporary capacity issues.

### Capacity Trends in Washington County

	FY2012	FY2013	FY2014
<i>Franklin Woods Community Hospital</i>			
Licensed Beds	80	80	80
Patient Days	14,233	15,199	15,182
Occupancy	49%	52%	52%
<i>Johnson City Medical Center</i>			
Licensed Beds	501	501	501
Patient Days	132,677	125,692	119,570
Occupancy	73%	69%	65%

Sources: Joint Annual Report; Internal Data

Given there is capacity at FWCH, JCMC will coordinate during peak census to ensure that the temporary removal of access to 34 of JCMC's licensed beds does not impact MSHA's overall ability to provide acute care services to the community. This challenge is only temporary as the ultimate goal is to relocate all 47 SNF beds (PTC's 34 beds and FTC's 13 beds) to the new eldercare campus that MSHA and Signature HealthCARE will be constructing on the old North Side Hospital campus. This disadvantage is offset by the fact JCMC will manage this challenge with other existing MSHA resources in Washington County and the only other viable alternatives are to hold on the improvements to QRH or to suspend PTC beds during the next 18 to 24 months as the new eldercare campus is constructed. MSHA believes these alternatives are not viable given the impact they would have on the entire delivery system and therefore seeks approval to temporarily relocate PTC to refurbished space within JCMC.

- b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.**

The aging baby boomer population is requiring an ever increasing demand for post-acute care. The increasing demand is the result of patients leaving a hospital setting and requiring skilled nursing assistance in hopes of re-acclimating to the lifestyle accustomed prior to the acute care setting. In February 2009, there was a report published that was prepared for the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services. This report, entitled "Examining Post-Acute Care Relationship in an Integrated Hospital System," identified

skilled nursing facilities as the most frequently used setting for Medicare patients seeking post-acute care, accounting for 41 percent of this population.

There has been renewed focus in the opportunity to better maximize skilled nursing facility and other post-acute care resources as bundled payments, ACOs, and other payment reform mechanisms continue to be implemented across the country. It is essential that patients receive the most appropriate care in the lowest cost setting and post-acute care is considered a significant opportunity to lower costs, improve quality through enhanced coordination of care, reduce hospital readmissions, and so forth. It was for these very reasons that MSHA begin to seek expertise in this area in the form of partnerships with HealthSouth and Signature HealthCARE.

Outlined below are the historical trends for SNF volumes at Princeton Transitional Care.

**Princeton Transitional Care Volumes**  
FY2010 – FY2014

	FY2010	FY2011	FY2012	FY2013	FY2014
Admissions	889	705	692	706	813
Patient Days	11,131	10,173	8,622	8,950	8,839
ALOS	12.5	14.4	12.5	12.7	10.9
Licensed Beds	34	34	34	34	34
Occupancy	89.7%	81.9%	69.5%	72.1%	71.2%

Sources: Joint Annual Reports; Internal Data

Sg2 is an international firm based out of Chicago, which provides analytic-based health care expertise to help hospitals and health systems integrate, prioritize and drive growth and performance across the continuum of care. Over 1,200 organizations around the world utilize their analytic, intelligence, consulting, and educational services. MSHA is a client and uses their analytic tools to project demand across the various setting within healthcare. Nationally Sg2 projects skilled nursing facility demand will grow over 10% over the next 10 years. The need for skilled nursing facility services will continue in PTC's local service area, especially given the higher than national rates of elderly. The ultimate goal of partnering with Signature HealthCARE to develop an eldercare campus that will provide coordinated care options for those requiring skilled care, assisted living or even just retirement living options will help meet this increasing need.

**3. For renovation or expansions of an existing licensed health care institution:**

- a. **The applicant should demonstrate that there is an acceptable existing demand for the proposed project.**

Question 3(a) is addressed in the question above [Question 2(b)].

- b. **The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.**

This is not applicable as this project involves only refurbishments and very minor renovation at JCMC in order to accommodate the request to temporarily

relocate PTC. The unit at JCMC was previously designated as skilled nursing facility space and will require only minimal adjustments to meet the needs of PTC.

**b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)**

**(4) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, the Commission may consider, in addition to the foregoing factors, the following factors:**

**(a) Need. The applicant should show the proposed new site will serve the healthcare needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change the proposed new site.**

The proposed relocation site for Princeton Transitional Care, currently located at Quillen Rehabilitation Hospital, is located approximately 4 miles away at Johnson City Medical Center. Because of the proximity of the two facilities, the skilled nursing care needs in the community will be just as well served as at the current site. This request is to temporarily relocate PTC to JCMC, which will enable HealthSouth to proceed with its plan to improve the QRH's facility infrastructure and expand clinic programmatic space to better meet the needs of the inpatient rehabilitation patient population. Additionally, the temporary relocation 4 miles away will ensure PTC continues to provide this vital service to the community while the intended permanent location is being built on the pending MSHA/Signature HealthCARE eldercare campus. This new eldercare campus will be on the old North Side Hospital property which is adjacent to the current campus of QRH. So while PTC will move 4 miles away temporarily, it will essentially end up back at nearly the same location, albeit in a modern, comprehensive campus designed to meet the needs of the elderly population through the provision of skilled care, assisted living services and retirement living options.

**(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.**

Approval of this project will enable Mountain States Health Alliance to enhance the provision of post-acute care services within Washington County. The ultimate intent of constructing an eldercare campus that will contain access to skilled nursing care, assisted living and retirement living options will better meet the needs of community. Enhancement of valued post-acute care services will improve cost efficiencies for the overall healthcare delivery system as the cost of care for patients in an acute care setting is almost 40% to 60% more compared to the post-acute care settings (i.e., skilled nursing, rehabilitation, and so forth). So improving access to this vital services in an elderly friendly environment that leverages the expertise of national and multi-state organizations such as HealthSouth and Signature HealthCARE will be very beneficial to this patient population.

**(c) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are**

**outweighed by the benefit that will be gained from the change of site by the population to be served.**

The proposed change of site of PTC from QRH to JCMC will not create any potential delays. Johnson City Medical Center does not currently operate at maximum capacity so there will be no delay or interruption in current clinical services at JCMC as the minor refurbishments are completed to prepare the facility for the relocation of PTC. In the meantime, PTC will continue to operate within QRH and will not be impacted during this brief time of preparation. Once the refurbishments at Johnson City Medical Center are complete, existing patients from Princeton Transitional Care would be transferred as appropriate to the new space within JCMC. In fact, by moving PTC to JCMC now, HealthSouth will have more immediate access to additional space at QRH needed to expand the clinical services programming and modernize the facility infrastructure for their inpatient rehabilitation patient population.

**2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.**

The proposed project is consistent with the long-range plans of Mountain States Health Alliance. As the healthcare delivery and reimbursement models have been changing in response to healthcare reform, there has been increased focus and attention given to post-acute care services. While MSHA has multiple resources in Washington County in this area (inpatient rehab, skilled nursing facilities), the system has not necessarily maximized the potential opportunities to completely leverage these resources. Recognizing that MSHA has limited expertise in these areas, the system intentionally sought out regional and national experts with whom MSHA could partner in these areas. Following a very thorough and methodical process, MSHA has decided to partner with HealthSouth for inpatient rehabilitation services (through a joint venture relationship with will involve QRH) as well as Signature HealthCARE for skilled nursing and other elder care services.

Both partners will bring a great deal of expertise and resources to the already existing services in place. HealthSouth is the nation's largest owner and operator of inpatient rehabilitation hospitals in terms of patients treated and discharged, revenues and number of hospitals. Operating in 28 states across the country and in Puerto Rico, HealthSouth serves patients through its network of inpatient rehabilitation hospitals, outpatient rehabilitation satellite clinics and home health agencies. HealthSouth's hospitals provide a higher level of rehabilitative care to patients who are recovering from conditions such as stroke and other neurological disorders, orthopedic, cardiac and pulmonary conditions, brain and spinal cord injuries, and amputations. MSHA intends to utilize this national partner to improve and expand the depth and breadth of inpatient rehabilitation services provided at QRH. In order to accomplish this, more space is needed within the building and therein lies part of the impetus of this project – to relocate PTC out of QRH, freeing up space for improvements to the inpatient rehabilitation services.

MSHA's second partner, Signature HealthCARE, is a growing long-term care, rehabilitation and health care provider with 123 locations in ten states and nearly 19,000 employees. Nearly half of Signature's facilities have 4-star or 5-star rating from the federal Centers for Medicare & Medicaid Services. In 2013, the company was named one of Modern Healthcare's "Best Places to Work" for the third time. Signature's culture was built on three organizational pillars: Learning, Spirituality and Intra-preneurship. This will be good fit with MSHA's culture and their regional expertise in skilled nursing care will be a tremendous value-add for the local community. MSHA intends to partner with Signature HealthCARE to construct a

comprehensive elder care campus, on the old North Side Hospital building site. This community and patient friendly campus will provide a range of elder care options, including skilled nursing care, assisted living and retirement living. This will greatly expand services for the elderly population within PTC's service area.

Both of these partnerships will enhance the quality of post-acute care services in the local community in a very coordinated fashion with the existing acute care resources. The eldercare campus that MSHA and Signature HealthCARE will develop is the intended ultimate home for PTC. However, given the multiple projects competing for the same space, MSHA has decided to temporarily relocate PTC to JCMC. This will ensure the community can still access this much needed service during this time of construction. Signature HealthCARE will be managing this unit at PTC so the partnership will have immediate benefit to the community as their expertise will be leveraged well prior to the construction of the eldercare campus.

3. **Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

Princeton Transitional Care serves patients predominately from Northeast Tennessee. The primary service area (PSA) consists of three Tennessee counties: Carter, Sullivan, and Washington. In Fiscal Year 2014, the PSA accounted for 675 SNF admissions, or 83% of total admissions to Princeton Transitional Care.

The secondary service area (SSA) consists of three other Tennessee counties: Johnson, Greene, and Unicoi. In Fiscal Year 2014, the SSA accounted for 82 SNF admissions, or 10% of total admissions to Princeton Transitional Care.

The FY2014 volumes by service area are provided in the following table.

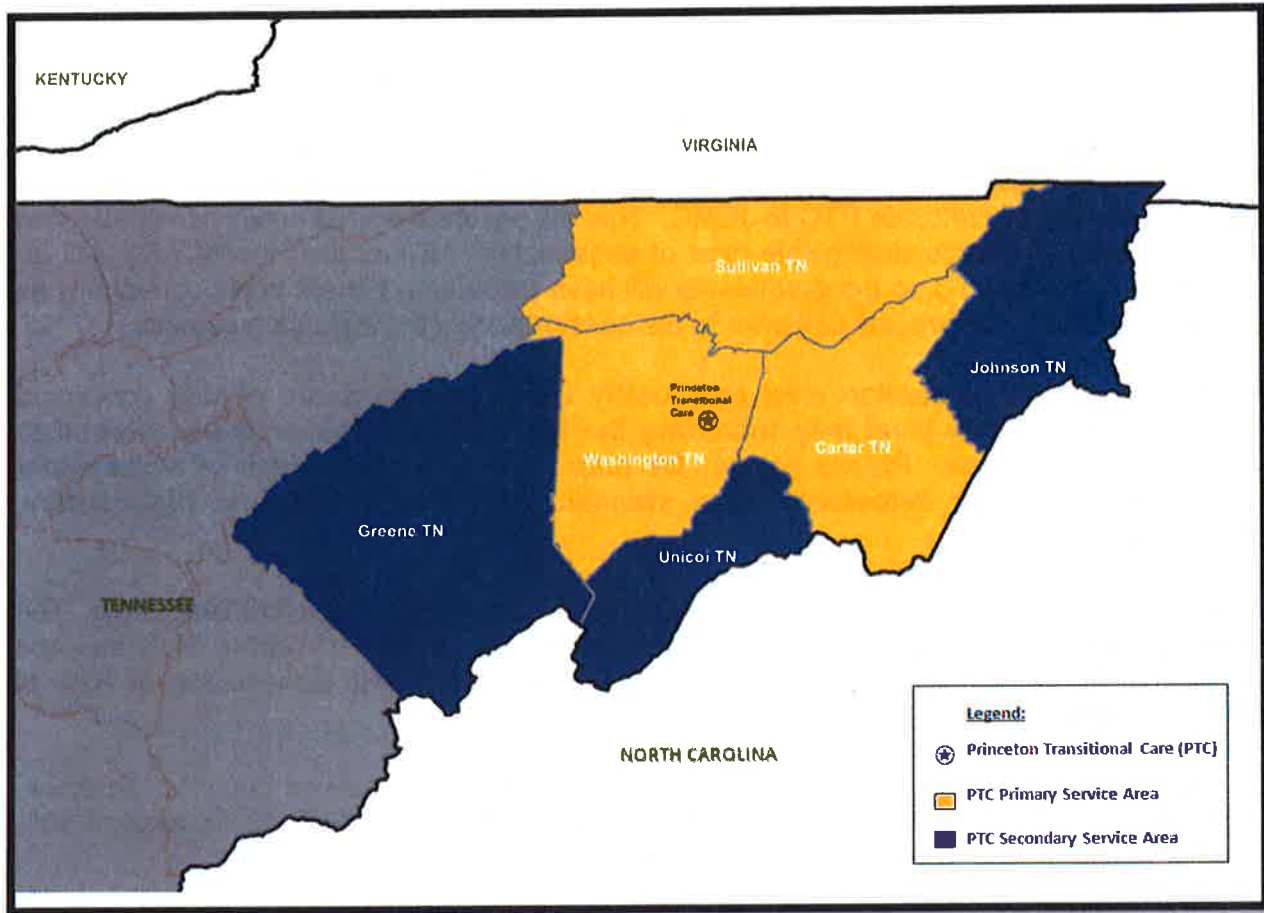
**FY2014 Princeton Transitional Care SNF Patient Origin**

Service Area	County	FY14 Cases	% of Total	Cumulative Total
Primary	Washington, TN	519	64%	64%
Primary	Carter, TN	92	11%	75%
Primary	Sullivan, TN	64	8%	83%
<i>PSA Subtotal</i>		675	83%	
Secondary	Unicoi, TN	32	4%	87%
Secondary	Greene, TN	32	4%	91%
Secondary	Johnson, TN	18	2%	93%
<i>SSA Subtotal</i>		82	10%	
<i>All Other</i>		56	7%	100%
<b>Grand Total</b>		<b>813</b>	<b>100%</b>	

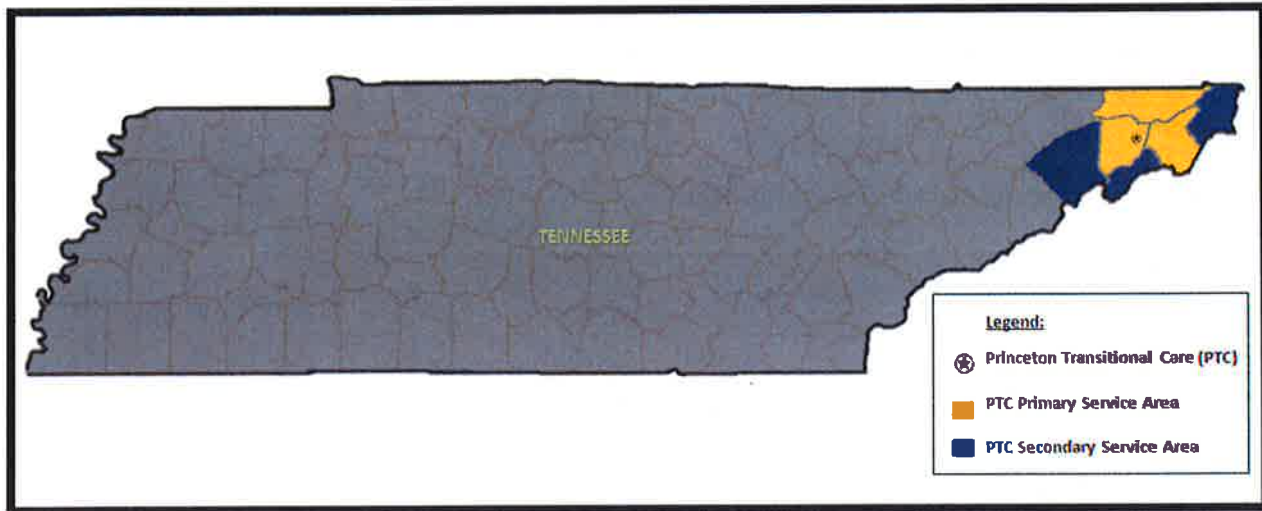
Source: Internal Data

Maps depicting the service area are provided on the following pages.

# Princeton Transitional Care SNF Service Area Map



# SNF Service Area Map



**A. Describe the demographics of the population to be served by this proposal.**

The following table shows the total population of each of the counties in the project's service area. Analysis of the data predicts a 3.0% growth in the combined primary and secondary service area of Princeton Transitional Care from 2015 to 2020. In addition, PTC is located in Washington County which expects a 6.7% growth over the next 5 years.

**Service Area Population Projections**

Service Area	County	2015	2020	5-Year Growth	
				Number	Percent
Primary	Washington, TN	132,015	140,905	8,890	7%
Primary	Carter, TN	58,052	58,375	323	1%
Primary	Sullivan, TN	158,679	159,749	1,070	1%
<i>PSA Subtotal</i>		<i>348,746</i>	<i>359,029</i>	<i>10,283</i>	<i>3%</i>
Secondary	Unicoi, TN	18,760	19,150	390	2%
Secondary	Greene, TN	71,945	74,656	2,711	4%
Secondary	Johnson, TN	18,716	19,112	396	2%
<i>SSA Subtotal</i>		<i>109,421</i>	<i>112,918</i>	<i>3,497</i>	<i>3%</i>
<b>PSA and SSA Combined</b>		<b>458,167</b>	<b>471,947</b>	<b>13,780</b>	<b>3%</b>

Source: Tennessee Advisory Commission on Intergovernmental Relations; University of Tennessee Center for Business and Economic Research

The population in the project's primary service area (accounts for 83% of service volume discharges) has a higher concentration of older individuals than state and national trends. In 2015, 20% of the project's service area will be ages 65 and above, compared to 16% in Tennessee and 15% of the United States. Over the next five years, the elderly population within the primary service area is projected to increase 16%, far outweighing general population growth of 3 percent. This growth substantiates the continued demand for services highly utilized by the elderly, including skilled nursing care, assisted living, and retirement living. The table below details the service area's age distribution.

**Primary Service Area Population Distribution by Age Group**

Age Cohort	2015	2020	% Growth	Percent of Total	
				2015	2020
0 to 19	78,111	78,113	0%	22%	22%
20 to 44	103,867	103,930	0%	30%	29%
45 to 64	97,899	97,307	-1%	28%	27%
65+	68,869	79,679	16%	20%	22%
<b>Total</b>	<b>348,746</b>	<b>359,029</b>	<b>3%</b>	<b>100%</b>	<b>100%</b>

Source: Tennessee Advisory Commission on Intergovernmental Relations; University of Tennessee Center for Business and Economic Research

The demographics of Princeton Transitional Care's primary service area are similar to the United States in gender (51 percent female, 49 percent male). The primary service area counties have a much lower median household income compared to the national average (\$40,216 versus \$51,371). The racial mix in the primary service area is predominately Caucasian, as they account for more than 92% percent of the population.

- B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.**

Princeton Transitional Care, as part of Mountain States Health Alliance, is committed to meeting the needs of the community and the region, as stated in its organizational mission, "to identify and respond to the health care needs of individuals and communities in our region and to assist them in attaining their highest possible level of health". Princeton Transitional Care participates in Medicare and TennCare programs. Mountain States Health Alliance provides services to more TennCare patients than any other provider in the region and is a leading provider of charity care. Medicare patients for FY2014 comprised 71% of Princeton Transitional Care's patient revenue, TennCare and Medicaid patients made up 7%, with another 12% combined from charity and self-pay.

- 5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.**

The proposed project is for the relocation of a 34-bed skilled nursing unit temporarily to Johnson City Medical Center while the elder care campus to be constructed by MSHA and Signature HealthCARE is being built. The trend in volumes is listed below for the hospitals in the service area providing skilled nursing services.

**Legend for Utilization Table**

Facility	Facility Name	SNF Name
IPMC	Indian Path Medical Center	IPMC Transitional Care
JCMC (a)	Johnson City Medical Center	Franklin Transitional Care
LMH (b)	Laughlin Memorial Hospital	Laughlin Healthcare Center
QRH	James H. and Cecile C. Quillen Rehabilitation Hospital	Princeton Transitional Care
UCMH (b)	Unicoi County Memorial Hospital	Unicoi County Nursing Home

(a) Franklin Transitional Care – currently suspended

(b) Provides Level I Intermediate Care services as well

### Trend in Service Area Hospital-Based SNF Utilization

Facility	Admissions (c)			Patient Days (c)			Licensed Beds			Occupancy (%)		
	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
IPMC	678	663	656	6,231	5,917	5,919	22	22	22	77.6%	73.7%	73.7%
JCMC (a)	10	291	n/a	84	3,571	n/a	13	13	13	1.8%	75.2%	n/a
LMH(b)	452	409	n/a	30,132	28,891	n/a	90	90	90	91.7%	87.9%	n/a
QRH	705	692	706	10,173	8,622	8,950	34	34	34	81.9%	69.5%	72.1%
UCMH (b)	83	103	108	16,655	16,574	15,847	46	46	46	99.2%	98.7%	94.4%

Sources: Tennessee Department of Health, Joint Annual Reports and Internal Data

Note: 2013 Joint Annual Reports not available for competitors

(a) Franklin Transitional Care was suspended between 2010 and 2011; it was then active in 2012 and re-suspended in 2013

(b) Provides Level I Intermediate Care services as well

(c) Includes Level I Intermediate and Level II Skilled Nursing where applicable

- 6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.**

Over the past five years, Princeton Transitional Care has operated at occupancy in excess of 70 percent. Mountain States Health Alliance anticipates a trend similar to the past with occupancy projections of 72% in the first full year and 77% in the second full year of operations. The projected data for the first full year of operations for Princeton Transitional Care at JCMC are 8,921 patient days and 805 admissions. The table below illustrates the historical and projected volumes for the 34-bed SNF unit.

#### Princeton Transitional Care SNF Volumes

FY2017 – Projected Year 2

	FY2010	FY2011	FY2012	FY2013	FY2014		FY2016	FY2017
Admissions	889	705	692	706	813		805	859
Patient Days	11,131	10,173	8,622	8,950	8,839		8,921	9,516
ALOS	12.5	14.4	12.5	12.7	10.9		11.1	11.1
Licensed Beds	34	34	34	34	34		34	34
Occupancy	89.7%	81.9%	69.5%	72.1%	71.2%		71.9%	76.7%

Sources: Joint Annual Reports; Internal Data

The growth was calculated assuming Princeton Transitional Care would achieve an average daily census of 26. Assessing historical and market trends, senior leadership assumed a modest growth of 1% for the project year 1 increasing to 6% in year 2 of the proposed project. These are very consistent with previous years.

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.
  - All projects should have a project cost of at least \$3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)
  - The cost of any lease should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater.
  - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.
  - For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.

The project costs associated with this proposal are identified in the Project Costs Chart below. Attachment C1 contains documentation support from an architect.

**PROJECT COSTS CHART**

44

<b>A. Construction and equipment acquired by purchase:</b>		
1. Architectural and Engineering Fees		<u>\$0</u>
2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees		<u>\$3,500</u>
3. Acquisition of Site		<u>\$0</u>
4. Preparation of Site		<u>\$0</u>
5. Construction Costs		<u>\$10,500</u>
6. Contingency Fund		<u>\$4,000</u>
7. Fixed Equipment (Not included in Construction Contract)		<u>\$0</u>
8. Moveable Equipment (List all equipment over \$50,000)		<u>\$0</u>
9. Other (Specify) _____		<u>\$0</u>
<b>B. Acquisition by gift, donation, or lease:</b>		
1. Facility (inclusive of building and land)		<u>\$0</u>
2. Building only		<u>\$0</u>
3. Land only		<u>\$0</u>
4. Equipment (Specify) _____		<u>\$0</u>
5. Other (Specify) _____		<u>\$0</u>
<b>C. Financing Costs and Fees:</b>		
1. Interim Financing		<u>\$0</u>
2. Underwriting Costs		<u>\$0</u>
3. Reserve for One Year's Debt Service		<u>\$0</u>
4. Other (Specify) _____		<u>\$0</u>
<b>D. Estimated Project Cost (A+B+C)</b>		<u><b>\$18,000</b></u>
<b>E. CON Filing Fee</b>		<u><b>\$3,000</b></u>
<b>F. Total Estimated Project Cost (D+E)</b>		
<b>TOTAL</b>		<u><b>\$ 21,000</b></u>

**2. Identify the funding sources for this project<sup>45</sup>****September 29, 2014****10:30 am**

Please check the applicable item(s) below and briefly summarize how the project will be financed. (*Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.*)

- ☐ A. **Commercial loan**—Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;
- ☐ B. **Tax-exempt bonds**—Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;
- ☐ C. **General obligation bonds**—Copy of resolution from issuing authority or minutes from the appropriate meeting.
- ☐ D. **Grants**—Notification of intent form for grant application or notice of grant award; or
- ☒ E. **Cash Reserves**—Appropriate documentation from Chief Financial Officer.
- ☐ F. **Other**—Identify and document funding from all other sources.

The project will be funded from existing cash reserves from operations at Mountain States Health Alliance. Documentation of the availability of funds to complete the project is provided in the attachments.

**3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.**

The total construction cost of the proposed project is minimal at \$10,500 in refurbishment and minor renovation cost. The renovations will focus on expanding the day room space needed to meet the standards required for a 34-bed skilled nursing facility as this space previously housed a smaller skilled nursing unit. The project will impact 14,334 square feet at a minimal cost of \$0.73 per square foot.

**4. Complete Historical and Projected Data Charts on the following two pages--Do not modify the Charts provided or submit Chart substitutions! Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).**

The following two pages contain the Historical Data Chart and the Projected Data Chart. The historical data chart profiles JCMC's performance between FY2012 and FY2014. The projected data chart profiles PTC's estimated performance for the first two complete fiscal years of operation (FY2016 and FY2017).

## HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency.  
The fiscal year begins in July.

**September 29, 2014**  
**10:30 am**

**Johnson City Medical Center:**

	<u>Year FY2012</u>	<u>Year FY2013</u>	<u>Year FY2014</u>
A. Utilization Data (adjusted patient days)	<u>221,073</u>	<u>221,457</u>	<u>211,147</u>
B. Revenue from Services to Patients			
1. Inpatient Services	<u>1,229,828,177</u>	<u>1,225,715,583</u>	<u>1,238,569,182</u>
2. Outpatient Services	<u>634,541,928</u>	<u>650,543,168</u>	<u>728,794,601</u>
3. Emergency Services	<u>63,778,997</u>	<u>70,645,530</u>	<u>75,596,172</u>
4. Other Operating Revenue (Specify) _____	<u>7,159,508</u>	<u>12,167,594</u>	<u>10,581,953</u>
<b>Gross Operating Revenue</b>	<b><u>1,935,308,611</u></b>	<b><u>1,959,071,875</u></b>	<b><u>2,053,541,908</u></b>
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	<u>1,387,754,477</u>	<u>1,445,591,862</u>	<u>1,551,293,701</u>
2. Provision for Charity Care	<u>102,833,165</u>	<u>92,919,891</u>	<u>90,618,603</u>
3. Provisions for Bad Debt	<u>2,231,217</u>	<u>2,459,181</u>	<u>5,863,379</u>
<b>Total Deductions</b>	<b><u>1,492,818,859</u></b>	<b><u>1,540,970,934</u></b>	<b><u>1,647,775,683</u></b>
<b>NET OPERATING REVENUE</b>	<b><u>442,489,752</u></b>	<b><u>418,100,940</u></b>	<b><u>405,766,225</u></b>
D. Operating Expenses			
1. Salaries and Wages	<u>170,489,724</u>	<u>164,639,656</u>	<u>153,036,891</u>
2. Physician's Salaries and Wages	<u>-</u>	<u>36,981</u>	<u>51,517</u>
3. Supplies	<u>93,918,752</u>	<u>88,161,682</u>	<u>88,675,272</u>
4. Taxes	<u>-</u>	<u>-</u>	<u>-</u>
5. Depreciation	<u>22,633,162</u>	<u>24,008,010</u>	<u>20,332,137</u>
6. Rent	<u>-</u>	<u>-</u>	<u>-</u>
7. Interest, other than Capital	<u>-</u>	<u>2,020,515</u>	<u>1,659,832</u>
8. Management Fees:			
a. Fees to Affiliates	<u>-</u>	<u>-</u>	<u>-</u>
b. Fees to Non-Affiliates	<u>-</u>	<u>-</u>	<u>-</u>
9. Other Expenses – Fees, Utilities, Other	<u>87,840,480</u>	<u>96,365,062</u>	<u>97,938,058</u>
<b>Total Operating Expenses</b>	<b><u>374,882,118</u></b>	<b><u>375,231,906</u></b>	<b><u>361,693,707</u></b>
E. Other Revenue (Expenses) – Net (Specify) _____	<u>-</u>	<u>-</u>	<u>-</u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>67,607,634</u></b>	<b><u>42,869,034</u></b>	<b><u>44,072,518</u></b>
F. Capital Expenditures			
1. Retirement of Principal	<u>212,049</u>	<u>229,830</u>	<u>238,712</u>
2. Interest	<u>16,555,757</u>	<u>13,340,567</u>	<u>14,076,703</u>
<b>Total Capital Expenditures</b>	<b><u>16,767,806</u></b>	<b><u>13,570,397</u></b>	<b><u>14,315,415</u></b>
<b>NET OPERATING INCOME (LOSS)</b>			
<b>LESS CAPITAL EXPENDITURES</b>	<b><u>50,839,828</u></b>	<b><u>29,298,637</u></b>	<b><u>29,757,103</u></b>

47  
PROJECTED DATA CHART

September 29, 2014

10:30 am

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in July.

**Princeton Transitional Care Unit:**

	<u>Year FY2016</u>	<u>Year FY2017</u>
A. Utilization Data (patient days)	<u>8,921</u>	<u>9,516</u>
B. Revenue from Services to Patients		
1. Inpatient Services	<u>22,033,086</u>	<u>23,502,617</u>
2. Outpatient Services	<u>                    </u>	<u>                    </u>
3. Emergency Services	<u>                    </u>	<u>                    </u>
4. Other Operating Revenue (Specify) <u>                                    </u>	<u>                    </u>	<u>                    </u>
<b>Gross Operating Revenue</b>	<b><u>22,033,086</u></b>	<b><u>23,502,617</u></b>
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	<u>16,963,511</u>	<u>18,075,572</u>
2. Provision for Charity Care	<u>740,563</u>	<u>792,783</u>
3. Provisions for Bad Debt	<u>624,654</u>	<u>668,700</u>
<b>Total Deductions</b>	<b><u>18,328,729</u></b>	<b><u>19,537,055</u></b>
<b>NET OPERATING REVENUE</b>	<b><u>3,704,357</u></b>	<b><u>3,965,562</u></b>
D. Operating Expenses		
1. Salaries and Wages	<u>2,754,971</u>	<u>2,938,718</u>
2. Physician's Salaries and Wages	<u>                    </u>	<u>                    </u>
3. Supplies	<u>729,559</u>	<u>778,218</u>
4. Taxes	<u>                    </u>	<u>                    </u>
5. Depreciation	<u>                    </u>	<u>                    </u>
6. Rent	<u>                    </u>	<u>                    </u>
7. Interest, other than Capital	<u>                    </u>	<u>                    </u>
8. Management Fees:		
a. Fees to Affiliates	<u>                    </u>	<u>                    </u>
b. Fees to Non-Affiliates	<u>129,484</u>	<u>138,120</u>
9. Other Expenses -- <u>Indirect Expenses</u>	<u>232,111</u>	<u>248,256</u>
<b>Total Operating Expenses</b>	<b><u>3,846,124</u></b>	<b><u>4,103,312</u></b>
E. Other Revenue (Expenses) -- Net (Specify) <u>                                    </u>	<u>                    </u>	<u>                    </u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>(141,767)</u></b>	<b><u>(137,750)</u></b>
F. Capital Expenditures		
1. Retirement of Principal	<u>                    </u>	<u>                    </u>
2. Interest	<u>                    </u>	<u>                    </u>
<b>Total Capital Expenditures</b>	<u>                    </u>	<u>                    </u>
<b>NET OPERATING INCOME (LOSS)</b>	<b><u>(141,767)</u></b>	<b><u>(137,750)</u></b>
<b>LESS CAPITAL EXPENDITURES</b>		

## HISTORICAL DATA CHART-OTHER EXPENSES

**OTHER EXPENSES CATEGORIES**

	Year 2012	Year 2013	Year 2014
1 Fees	\$ 48,782,269	\$ 55,836,232	\$ 58,798,969
2 Utilities	\$ 5,490,333	\$ 5,171,544	\$ 5,246,550
3 Amortization	\$ 46,949	\$ 47,667	\$ 47,587
4 Consolidation Allocation	\$ 13,095,714	\$ 18,077,359	\$ 16,658,279
5 Insurance	\$ 1,118,158	\$ 541,691	\$ 1,214,995
6 Lease	\$ 1,705,486	\$ 1,944,649	\$ 1,757,017
7 Travel	\$ 467,779	\$ 298,104	\$ 226,145
8 OtherExp	\$ 2,418,741	\$ 2,203,472	\$ 2,022,912
9 Dues&Subs	\$ 786,291	\$ 984,607	\$ 978,796
10 Maintenance	\$ 12,814,602	\$ 10,336,422	\$ 10,107,699
11 Marketing	\$ 817,435	\$ 603,679	\$ 475,296
12 Employee	\$ 296,724	\$ 319,636	\$ 403,813
<b>Total Other Expenses</b>	<b>\$ 87,840,480</b>	<b>\$ 96,365,062</b>	<b>\$ 97,938,058</b>

## PROJECTED DATA CHART-OTHER EXPENSES

**OTHER EXPENSES CATEGORIES**

	Year 2016	Year 2017
1 Allocated expenses	\$ 232,111	\$ 248,256
2	\$ -	\$ -
3	\$ -	\$ -
4	\$ -	\$ -
5	\$ -	\$ -
6	\$ -	\$ -
7	\$ -	\$ -
<b>Total Other Expenses</b>	<b>\$ 232,111</b>	<b>\$ 248,256</b>

5. **Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.**

The project's charge information is as follows:

Average gross charge:	\$2,470
Average deduction from operating revenue (contractual):	\$2,055
Average net charge:	\$415

6. **A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.**

Outlined below are the room and board current charges for the SNF patients at Princeton Transitional Care. Mountain States Health Alliance does not anticipate room rates to shift as a result of the proposed application.

**Current and Projected SNF Room Rates**

Description	FY2014
Semi-Private Room OVF/SNF	\$ 647
Private Room - SNF	\$ 776

**B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).**

The charges associated with skilled nursing services provided at Princeton Transitional Care, which are reasonable in comparison to rates of other providers in the area, will not change as a result of this project. The table below outlines comparison of Medicare/Skilled Care (average daily charge) and Medicaid/TennCare Level II (average daily charge) for Mountain States Health Alliance hospital-based facilities with other hospital-based skilled nursing facilities across Tennessee. Because the charges reported on the Joint Annual Report are combined for both Level I Intermediate and Level II Skilled Nursing Care, only facilities with just skilled nursing care utilization were included below.

**Trend in Charge Comparison – Hospital-Based SNFs  
FY2010 – FY2012**

	Medicare/Skilled Care (Average Daily Charge)			Medicaid / TennCare Level II		
	2010	2011	2012	2010	2011	2012
Princeton Transitional Care	\$1,968	\$2,213	\$2,388	\$2,143	\$2,156	\$2,308
Franklin Transitional Care*	-----	\$2,827	\$2,711	-----	-----	\$2,514
Indian Path Medical Center Transitional Care	\$2,124	\$2,558	\$2,758	\$2,173	\$2,860	\$2,281
Fort Sanders Transitional Care Unit	\$1,253	\$1,358	\$1,357	-----	-----	-----
St. Mary's Transitional Care Unit	\$1,424	\$1,441	\$1,685	-----	-----	-----
Baptist Memorial Hospital- Memphis SNF	\$2,269	\$2,535	\$2,750	\$2,384	\$2,979	\$3,087
Baptist Skilled Rehabilitation Unit	\$1,604	\$1,808	\$1,952	-----	-----	-----
Methodist Healthcare Skilled Nursing Facility	\$1,493	\$1,667	\$1,718	-----	-----	-----

Source: Joint Annual Reports, only through 2012 is available

\* Franklin Transitional Care was suspended between 2010 and 2011; it was then active in 2012 and re-suspended in 2013

The table below depicts slightly higher average daily charges due to the severity of patients accepted by MSHA skilled nursing facilities. Further, the table below outlines a comparison of average charges and average charge per patient day for all Mountain States Health Alliance facilities in primary service area with skilled nursing facilities, other tertiary care facilities across the state and other hospitals in the service area with skilled nursing facilities.

**Trend in Charge Comparison – Hospitals  
2011-2013**

	Average Charge			Average Charge per Patient Day		
	2011	2012	2013	2011	2012	2013
Princeton Transitional Care	\$31,036	\$28,875	\$28,829	\$2,151	\$2,317	\$2,274
Franklin Transitional Care	\$32,449	\$33,781	-----	\$3,863	\$2,753	-----
IPMC	\$31,401	\$33,020	\$37,213	\$8,662	\$8,923	\$9,761
JCMC	\$43,835	\$45,655	\$47,980	\$9,016	\$9,120	\$9,792
QRH	\$38,737	\$41,699	\$44,091	\$3,038	\$3,175	\$3,367
Service Area - A	\$22,396	\$22,682	\$24,740	\$5,137	\$5,158	\$5,559
Service Area - B	\$28,154	\$29,133	\$30,177	\$6,091	\$6,437	\$6,880
Hospital - A (East TN)	\$36,624	\$38,090	\$40,579	\$6,564	\$7,032	\$7,535
Hospital - B (Middle TN)	\$55,510	\$55,247	\$53,618	\$10,530	\$10,126	\$10,262
Hospital - C (West TN)	\$49,402	\$51,211	\$54,648	\$7,646	\$7,762	\$7,955

Source: Tennessee Hospital Association's MarketIQ

Notes: data includes normal newborns and unknown MS-DRGs; FTC only had 10 admissions in 2011 as it was suspended between 2010 and 2011; it was then active in 2012 and re-suspended in 2013

- Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.**

The services provided by PTC are a much needed benefit to the community and by establishing a partnership with Signature HealthCARE, their management expertise will improve the financial performance of this service during this interim period as the new eldercare campus is constructed which will serve as the ultimate destination for PTC. As a not-for-profit health care provider there are many services provided that often operate with negative margins, however, it is MSHA's mission to "identify and respond to the health care needs of individuals and communities in our region and to assist them in attaining their highest possible level of health", even if it means some services do not operate with a positive margin. This is a needed service and without it, more costs could be incurred due to lengthened patient stays in the hospital if there are reduced options for skilled care transfers.

**8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.**

Revenue and expense information for this proposal for Years 1 and 2 following project completion is included in the Projected Data Chart. The cash flow as represented is projected to be (\$141,767) and (\$137,750) in years 1 and 2, respectively. As outlined above, the management agreement with Signature HealthCARE is projected to improve the financial performance during this interim period. This is not unique to this patient population, and both MSHA and Signature HealthCARE agree it is important to continue to provide these services to this patient population.

**9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.**

As with all facilities within Mountain States Health Alliance, Princeton Transitional Care is committed to meeting the needs of the community and the region, and will continue the provision of medically necessary care, regardless of socioeconomic status, payor source, age, race or gender. PTC participates in both Federal and State programs, including Medicare, TennCare and Medicaid programs. The following is the breakdown of TennCare, Medicaid, and Medicare for 2014:

Revenue Type	52 Total Charges	Payor Mix by Charges
Medicare	7,978,118	36%
Managed Medicare	7,674,254	35%
TennCare	1,253,225	6%
Medicaid	281,422	1%
Managed Care	313,953	1%
Blue Cross	1,118,528	5%
United – River Valley	402,030	2%
Commercial	350,617	2%
Self Pay	2,740,520	12%
Other	59,052	0%

MSHA provides services to more TennCare patients than any other provider in the region and is a leading provider of charity care.

10. **Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.**

The most recent reporting period audited balance sheets and income statements for Mountain States Health Alliance are located in the attachments (audited statements for Fiscal Year 2012 and 2013).

11. **Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:**
  - a. **A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.**

One option is to suspend Princeton Transitional Care until the new campus is complete. However, this would remove an existing service from the community and interrupt the care continuum needed by the existing patient population. These patients would need to seek care elsewhere, in many cases being forced to leave their local community. This will increase the expenses of those impacted families, but most important reduce the continuity of care and hinder the ability of families to provide the emotional support that patients need from them which aides in their recovery.

Another alternative is to continue to operate Princeton Transitional Care at its current location within Quillen Rehabilitation Hospital. This option would delay improvements in QRH that HealthSouth is finalizing to update and modernize facility infrastructure and clinical programming space which will enhance the patients overall experience and quality of care. If PTC is not temporarily relocated to JCMC, then the patients at QRH will not benefit from these improvements for at least another 18 to 24 months which is the time needed to complete the construction for PTC's ultimate destination.

The proposed project, or third option, involves temporarily relocating Princeton Transitional Care to Johnson City Medical Center at a cost of \$21,000. Given the proposed space at JCMC was previously used to house skilled nursing facility beds, it will require only minimal refurbishments to accommodate PTC. The proposed project will ensure continued provision of this service under the management of a very experienced, large-scale provider with 123 other locations across ten states. MSHA's and Signature HealthCARE's commitment to the continued provision of skilled nursing care in Washington County will ensure the community has access to this much needed, high-quality service as a larger elder care campus is being constructed which will offer an expanded variety of services for this population.

- b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.**

The component of the project Mountain States Health Alliance has requested in this application involves no new construction, only minor facility refurbishments. As described previously, this alternative temporarily moves a patient population to an appropriate care location while a more comprehensive elder care campus is being constructed.

### **(III.) CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE**

- 1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.**

Mountain States Health Alliance, Quillen Rehabilitation Hospital, Princeton Transitional Care and Johnson City Medical Center will continue to work closely with other healthcare providers in the region, including: Mountain States Health Alliance hospitals, affiliate hospitals in the Mountain States Healthcare Network, East Tennessee State University and the James H. Quillen College of Medicine, local nursing homes, clinics and other healthcare providers. The East Tennessee State University affiliation calls for JCMC to provide clinical training for medical students and residents in the areas of family medicine and psychiatric services.

- 2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.**

The proposed project is beneficial to the health care system and will result in no negative effects from unnecessary duplication of services or competition. The focus of the project is to enhance the overall post-acute care continuum in Washington County, TN by securing experienced partners who will elevate the quality of care and expand the scope of services available to the elderly population (i.e., assisted living and retirement living).

By leveraging existing resources, MSHA has a plan to temporarily relocate PTC's skilled nursing care beds to JCMC at a minimal cost. This plan ensures the continuation of this much needed service as enhancements are being made to the facility infrastructure and clinical service programming at QRH as well as during the development of an expansive elder care

community which will bring together a variety of needed living and care options of the elderly within the community. The proposal will not have any negative impacts on other providers as it is not seeking additional licensed beds. In addition, the proposal is not seeking the initiation of any new services and will result in a much improved environment to serve the post-acute care needs of the population.

3. **Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.**

The table below depicts the current staffing pattern for Princeton Transitional Care. Following the proposed move to Johnson City Medical Center and the initiation of Signature's management of the skilled nursing unit, there may be some adjustments to the skill level profile of the staff to ensure the most efficient delivery model.

Position	FTEs
Speech/Language Therapist	2.0
Registered nurse	10.5
Licensed practical nurse	4.2
Patient care partner	8.4
Activities Coordinator	1.0

The following table includes comparisons of the clinical staff salaries associated with the 34-bed SNF at QRH to the prevailing wage patterns as obtained by the Tennessee Society for Healthcare Human Resources Administration (TSHHRA) survey.

**Princeton Transitional Care**  
Salary Comparisons  
2013

POSITION	Statewide TSHHRA			Mountain States Health Alliance		
	Average 2013	Range Min	Range Max	Average 2013	Range Min	Range Max
RN	\$24.97	\$19.14	\$30.81	\$23.73	\$18.00	\$29.52
Licensed Practical Nurse	\$15.98	\$12.53	\$19.43	\$15.06	\$11.25	\$18.21
Patient Care Partner	\$11.46	\$8.89	\$14.04	\$11.13	\$9.00	\$14.76
Speech/Language Therapist	\$31.32	\$24.12	\$38.52	N/A	\$27.40	\$43.84
Activities Coordinator	\$13.45	\$10.28	\$16.62	\$12.22	\$8.39	\$13.42

Source: Compdata Tennessee Hospital Association/TSHHRA, 2013; internal data

4. **Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.**

Mountain States Health Alliance recruits and retains staff by offering salary and benefit packages appropriate for the market. Future staff additions will be the result of projected utilization which will occur regardless of whether this project is completed.

5. **Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.**

Mountain States Health Alliance and Princeton Transitional Care have reviewed and understand all licensing certifications as required by the State of Tennessee. Mountain States Health Alliance has policies and procedures in place governing regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping, and staff education.

6. **Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).**

Mountain States Health Alliance works extensively with local colleges and universities and is affiliated with the James H. Quillen College of Medicine, East Tennessee State University, located in Johnson City, Tennessee. MSHA has the largest number of medical residents in the Tri-Cities area, and this affiliation calls for Johnson City Medical Center to provide clinical training for medical students and residents in the areas of family medicine and psychiatric services.

7. (a) **Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.**

The proposed project will comply with licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and any applicable Medicare requirements.

- (b) **Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.**

**Licensure:**

Princeton Transitional Care is licensed as a skilled nursing facility by the Board for Licensing Health Care Facilities.

Johnson City Medical Center is licensed as a general hospital by the Board for Licensing Health Care Facilities.

**Accreditation:**

Johnson City Medical Center is accredited by The Joint Commission.

- (c) **If an existing institution, please describe current standing with any licensing, certifying, or accrediting agency or commission. Provide a copy of the current license of the facility.**

Both Princeton Transitional Care and Johnson City Medical Center are currently licensed by the Board of Licensing Health Care Facilities. Copies of the licenses are located in

the attachments [see Attachment C, Contribution to the Orderly Development of Health Care, 7(c)].

- (d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.**

A copy of the most recent Summary Statement of Deficiencies and the approved Provider's Plan of Correction, is located in the attachments [see Attachment C, Contribution to the Orderly Development of Health Care, 7(d)].

- 8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.**

Mountain States Health Alliance, owner and operator of Princeton Transitional Care and Johnson City Medical Center, has no final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant.

- 9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.**

There are no final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

- 10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.**

The applicant will, if approved, continue to provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated the number and type of procedures performed, and other data as requested.

57  
**PROOF OF PUBLICATION**

**Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.**

The full page of the newspaper in which the notice of intent appeared, with mast and dateline intact, is attached.

**DEVELOPMENT SCHEDULE**

**Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.**

- 1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
- 2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the "good cause" for such an extension.**

Form HF0004  
Revised 05/03/04  
Previous Forms are obsolete

## PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in Rule 68-11-1609(c): 12/17/2014

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

This project only involves minor refurbishments (patching and painting) and minor renovations to the day room to ensure compliance with current regulatory statutes.

<u>Phase</u>	<b>DAYS REQUIRED</b>	<b>Anticipated Date (MONTH/YEAR)</b>
1. Architectural and engineering contract signed	<u>                    </u>	<u>                    </u>
2. Construction documents approved by the Tennessee Department of Health	<u>40</u>	<u>                    </u>
3. Construction contract signed	<u>                    </u>	<u>                    </u>
4. Building permit secured	<u>                    </u>	<u>                    </u>
5. Site preparation completed	<u>                    </u>	<u>                    </u>
6. Building construction commenced	<u>                    </u>	<u>                    </u>
7. Construction 40% complete	<u>                    </u>	<u>                    </u>
8. Construction 80% complete	<u>                    </u>	<u>                    </u>
9. Construction 100% complete (approved for occupancy	<u>14</u>	<u>                    </u>
10. *Issuance of license	<u>                    </u>	<u>March 2015</u>
11. *Initiation of service	<u>                    </u>	<u>February 2015</u>
12. Final Architectural Certification of Payment	<u>                    </u>	<u>                    </u>
13. Final Project Report Form (HF0055)	<u>30</u>	<u>March 2015</u>

**\* For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

**Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.**

Mountain States Health Alliance  
Relocation of Princeton Transitional Care to Johnson City Medical Center Project  
Certificate of Need Application Attachments

Attachment A.3: Corporate Charter and Certificate of Incorporation and Certificate of Existence

Attachment A.4: Organizational Structure

Attachment A.6: Title / Deed / Legal Interest in Site

Attachment B.I: Letter of Intent from Signature HealthCARE

Attachment B.III.(A) & B.IV: Plot Plan & Floor Plans

Attachment C, Need 3: Service Area Maps

Attachment C, Economic Feasibility 1: Construction Costs Documentation

Attachment C, Economic Feasibility 2: Letter of Available Funds

Attachment C, Economic Feasibility 10: Balance Sheet and Income Statement for Mountain States Health Alliance: Most Recent Audited Statements – FY2012 and FY2013

Attachment C, Contribution to the Orderly Development of Health Care, 7(c): Current Licensure from Tennessee Department of Health and Joint Commission Accreditation

Attachment C, Contribution to the Orderly Development of Health Care, 7(d): Summary Statement of Deficiencies and (Approved) Provider's Plan of Correction

Attachment C, Proof of Publication: Publication of Intent, Johnson City Press

Attachment: Affidavit for Application

## **ATTACHMENT B.I**

### **Letter of Intent from Signature HealthCARE**



**SIGNATURE HEALTHCARE CONSULTING SERVICES, LLC**  
 12201 Bluegrass Parkway  
 Louisville, Kentucky 40299  
 Richard L. Tinsley  
 Ph: 502 568 7849 Fax: 502.259.0146  
[rtinsley@signaturehealthcarellc.com](mailto:rtinsley@signaturehealthcarellc.com)

September 9, 2014

**VIA EMAIL ONLY**

Mountain States Health Alliance  
 Attn: Grace Pereira

**Re: Non-Binding Letter of Intent**

Dear Ms. Pereira:

Signature HealthCARE, LLC or its designee ("SHC") is pleased to present to Mountain States Health Alliance ("MSHA") our proposal to manage a 34-bed skilled nursing unit (the "Unit") located within the Johnson City Medical Center located at 400 N. State of Franklin Road, Johnson City, TN 37604. SHC is excited about the prospects of the management arrangement and believes a satisfactory transaction can be concluded expeditiously.

This letter summarizes the major terms and conditions upon which SHC would consider undertaking the management of the Unit. These terms and conditions are as follows:

1. (a) SHC would manage the day-to-day operations of the Unit and in return would receive a management fee of five percent (5%) of gross revenues from the operations of the Unit.
- (b) SHC would be reimbursed for any costs or expenses it incurs in the delivery of its management services to the Unit.
2. Completion of the transaction will be conditional, among other matters, upon:
  - a) execution of the definitive Management Agreement containing representations, warranties, covenants and indemnities customary for a transaction of this type;
  - b) approval of all governmental agencies or authorities having jurisdiction over the Unit, including approval of relevant Certificate of Need Boards, if any, and consent by any lessors or financial institutions of the Unit, as may be required;
  - c) approval by Signature HealthCARE, LLC Executive Committee;

Mountain State Health Alliance  
September 3, 2014

3. Our objective is to enter into definitive agreements by October 31, 2014.

For a period of 60 days you agree to refrain from discussing, soliciting, entertaining or accepting other offers or proposals relating to the acquisition, lease or management of the Unit, and to cause the Unit and its affiliates, directors, employees and agents to do the same. Each of the parties shall be responsible for the fee of its own lawyers, accountants and other advisors and its other expenses or business losses incurred in respect of the negotiation of consummation of the transactions proposed herein. None of the parties hereto shall make any public statement with respect to the transactions proposed herein without the consent of the other parties. Each party will hold the other harmless from any broker's or finder's fees.

With the exception of the immediately preceding paragraph the provisions of which shall be binding, this letter is a statement of our mutual intentions and is not intended to create or result in any legally binding rights or obligations in or upon any of the parties hereto. If the parties hereto have not entered into definitive agreements prior to October 31, 2014, this proposal shall terminate other than with respect to the provisions of this paragraph, which provisions shall survive any such termination.

While there are many issues that will require discussion, we are confident these issues can be resolved expediently.

If you are in agreement with the above, kindly execute and return a duplicate original of this letter no later than September 11, 2014. Please contact me at your convenience so that we may arrange a mutually convenient time to meet and discuss any questions or concerns you may have about this proposal so that we may ensure that it meets your needs. If we do not receive this letter executed by your firm by that date, the offer contained in this letter is automatically withdrawn, null and void.

Sincerely,

  
Richard L. Tinsley  
Chief Development Officer

Accepted and agreed to this 10 day of September, 2014.

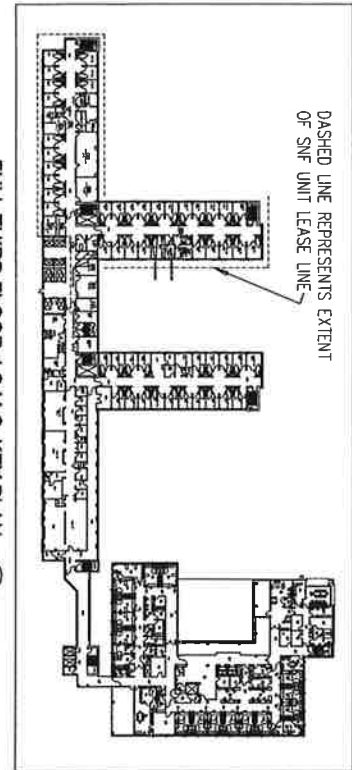
Mountain States Health Alliance

By:  VP

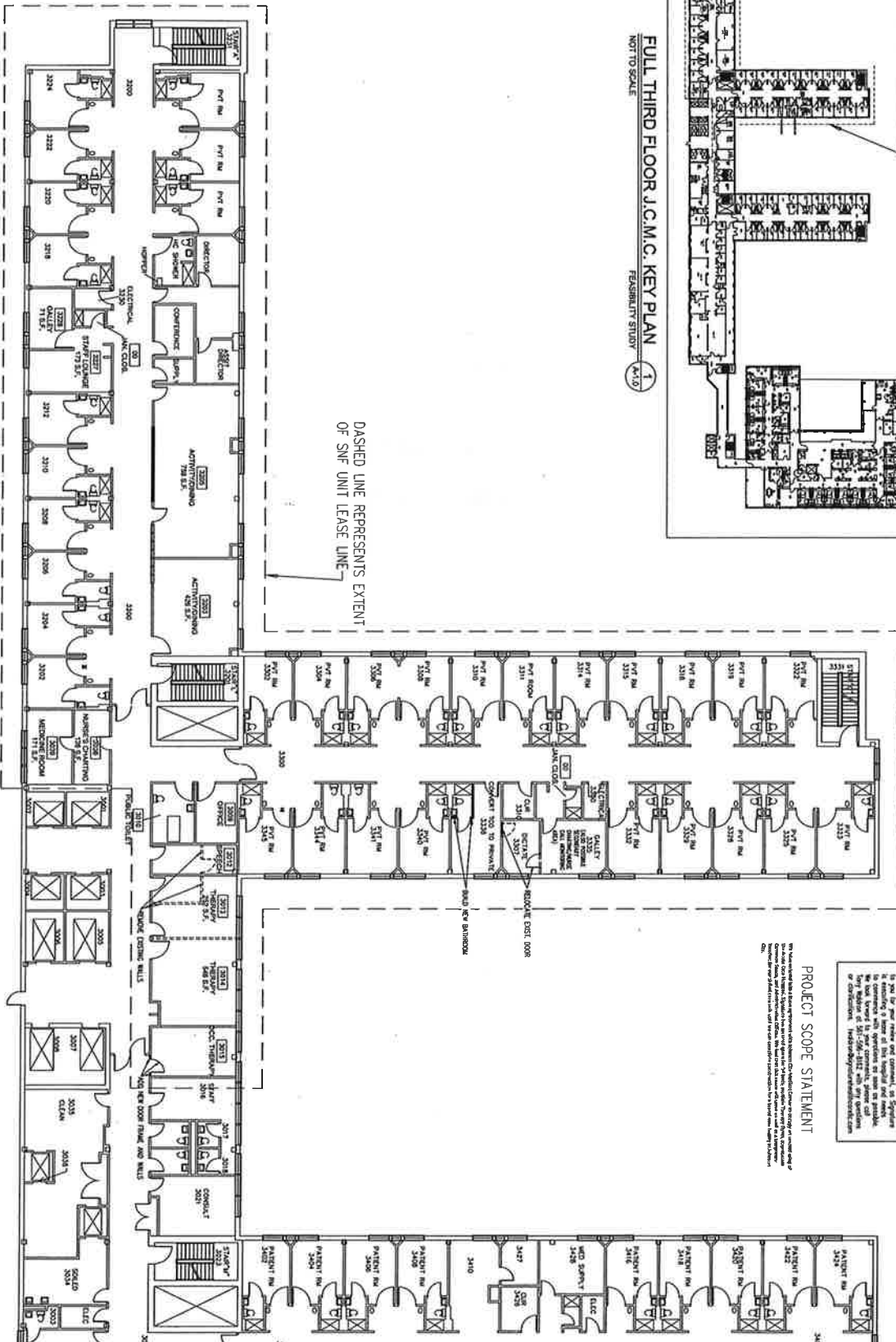
Date: 9/10/2014

**ATTACHMENT B.III. (A) & B.IV.**

- 1. Plot Plan**
- 2. Floor Plans**



FULL THIRD FLOOR J.C.M.C. KEY PLAN  
NOT TO SCALE  
FEASIBILITY STUDY A-1.0



PARTIAL THIRD FLOOR PLAN  
3/22" = 1'-0"  
FEASIBILITY STUDY A-1.0

# NOTE TO PLAN REVIEWER

For the purposes of plan review, it is not intended to accept the scope and content of this plan as a final design. The plan is intended to provide a general overview of the proposed project. The plan is not intended to be used for construction purposes. The plan is not intended to be used for any other purpose. The plan is not intended to be used for any other purpose.

## PROJECT SCOPE STATEMENT

The project is a 34-bed SNF unit for signature healthcare at Johnson City Medical Center. The project is a 34-bed SNF unit for signature healthcare at Johnson City Medical Center. The project is a 34-bed SNF unit for signature healthcare at Johnson City Medical Center. The project is a 34-bed SNF unit for signature healthcare at Johnson City Medical Center.

A-1.0

07/18/2014  
07/18/2014

34 BED SNF FOR SIGNATURE HEALTHCARE  
AT JOHNSON CITY MEDICAL CENTER, JOHNSON CITY, TN

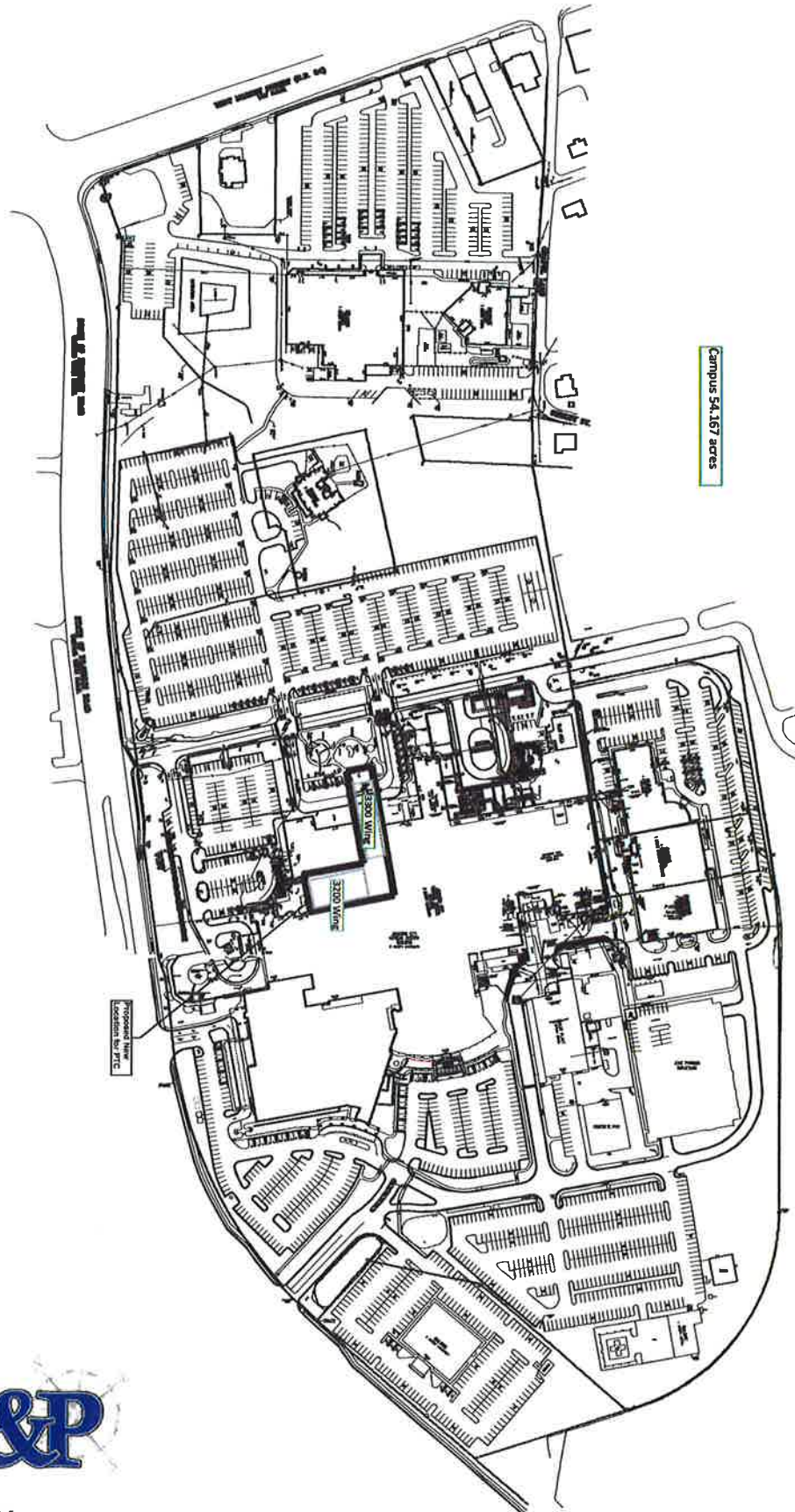
THIRD FLOOR PLAN

SHC SHORT TERM REHAB SNF UNIT AT  
JOHNSON CITY MEDICAL CENTER  
JOHNSON CITY, TENNESSEE

September 29, 2014

10:30 am

01-067-075

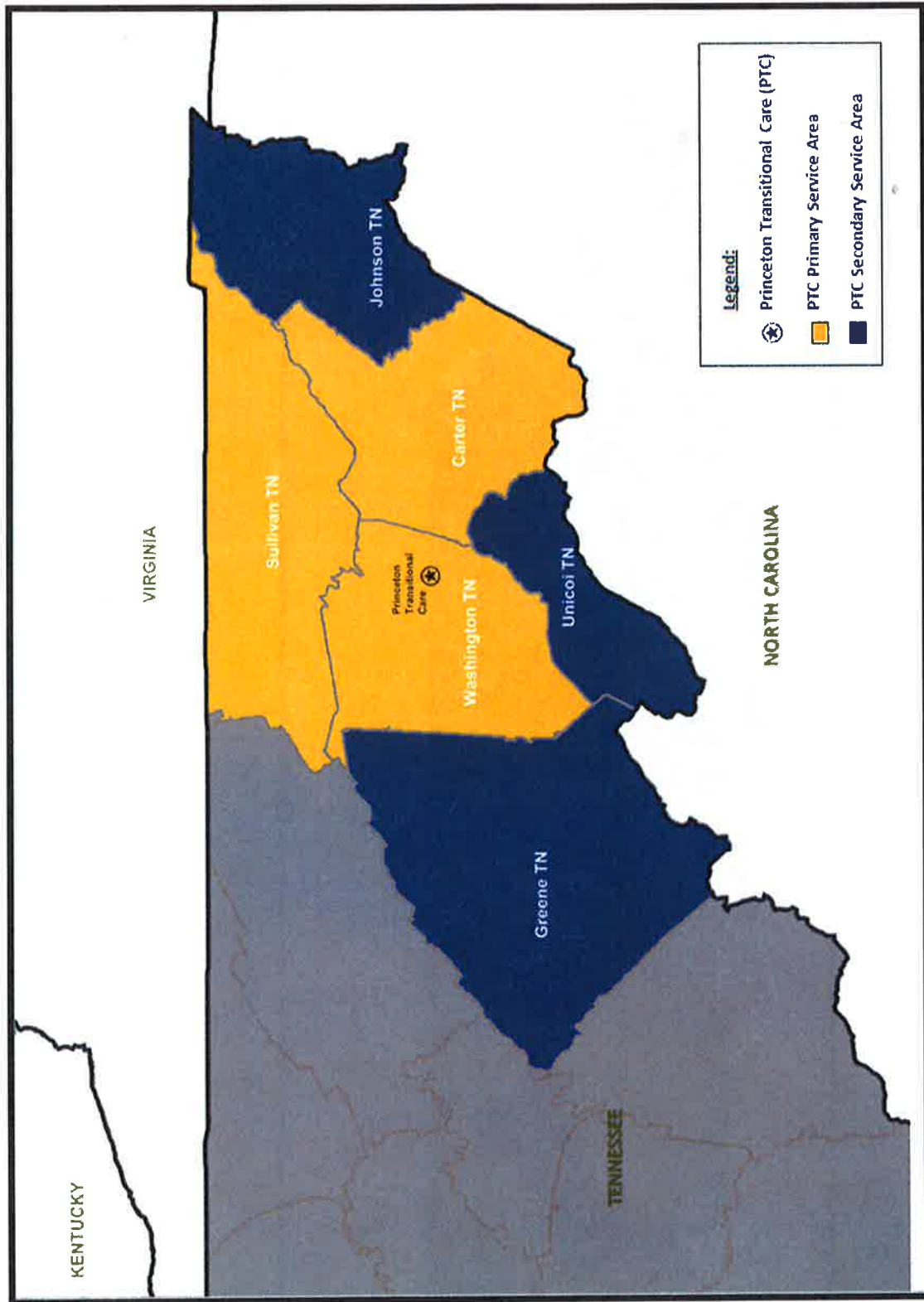


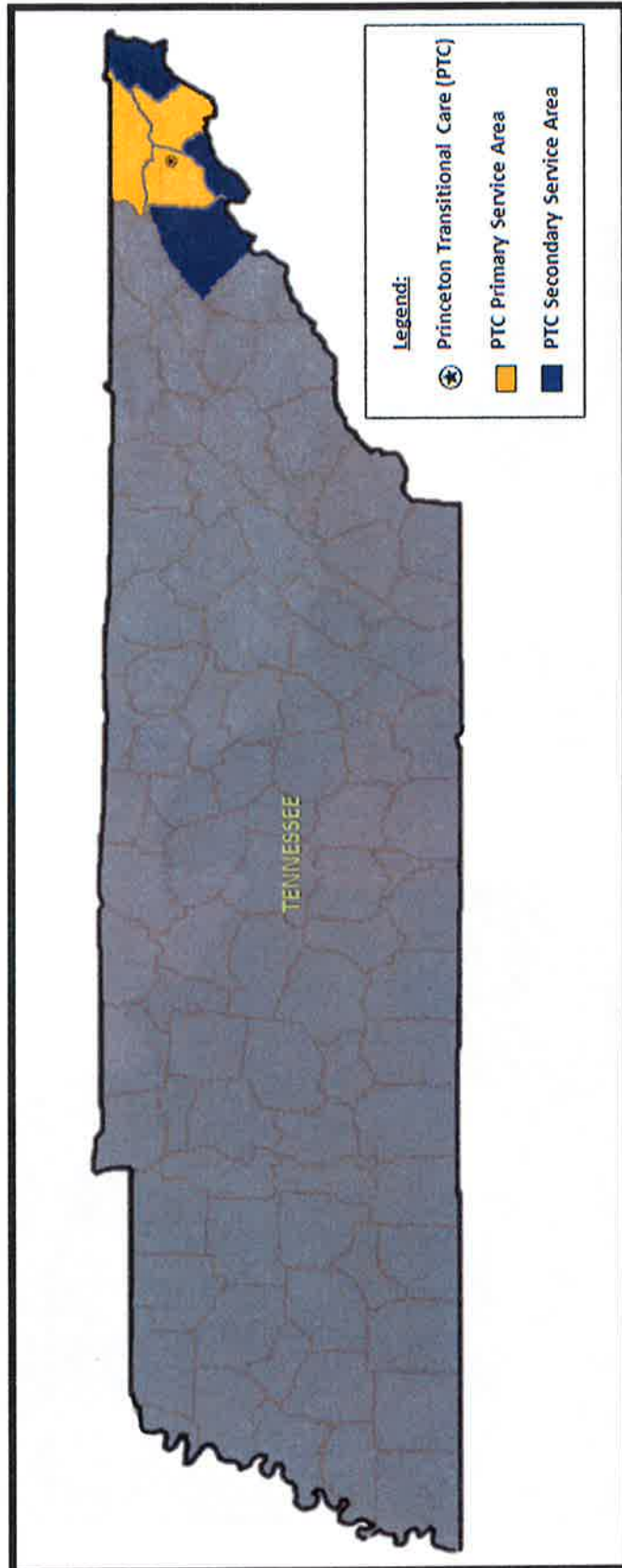
**TH&P**

JCMC Campus Map  
 Combination of survey & design jobs performed by TH&P, Inc. for MSHA  
 Date: 7/28/14  
 Scale: 1"=100'

**ATTACHMENT C, NEED (3)**

**Service Area Maps**





## **ATTACHMENTS C, ECONOMIC FEASIBILITY (1)**

**Architect Documentation for Support of Estimated Construction Costs**



Billy Teilhet, CBET, CHSP, CHFM, LEED AP  
Corporate Director Biomedical Services  
Mountain States Health Alliance  
108 Woodlawn, Suite 200A  
Johnson City, TN 37604

September 4, 2014

Re: Architects code review for proposed 34 Bed Skilled Nursing Unit at Johnson City  
Medical Center 3<sup>rd</sup> floor

Dear Mr. Teilhet:

During the course of reviewing and adjusting the plans provided to us by MSHA, it is my opinion that after some minor demolition of a few walls, the construction of one resident toilet room, a door relocation, the addition of a new door and filling in an existing opening, we will be able to adaptively reuse a few spaces in such a way that will render our layout in compliance with all applicable codes (2012 IBC, and 2012 NFPA 101) for the jurisdiction (State of Tennessee). The proposed construction associated costs of \$18,000 for these changes are reasonable in my opinion. Furthermore, the plan will contain all the requisite elements required by the 2010 edition of the Guidelines for the design and construction of healthcare facilities as well as the Americans with Disabilities Act Accessibility Guidelines.

I look forward to Signature Healthcare's partnership with Mountain States Health Alliance. Please feel free to contact me with questions or clarifications regarding the aforementioned project, or any other projects, as I am at your disposal.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "James A. Waldron". The signature is fluid and cursive, with a long, sweeping underline.

James A. (Tony) Waldron, AIA

## **ATTACHMENTS C, ECONOMIC FEASIBILITY (2)**

### **1. Letter of Available Funds**



**MOUNTAIN STATES  
HEALTH ALLIANCE**

**September 10, 2014**

**Tennessee Health Services and Development Agency  
Andrew Jackson Building, Ninth Floor  
502 Deaderick Street  
Nashville, TN 37243**

**Dear Agency Members:**

**This letter is to certify that Mountain States Health Alliance will use existing cash reserves to finance the expenses related to the project to relocate Princeton Transitional Care to Johnson City Medical Center.**

**Sincerely,**

**Lynn Krutak  
Senior Vice President/CFO**

## **ATTACHMENTS C, ECONOMIC FEASIBILITY (10)**

### **Balance Sheet and Income Statement for Mountain States Health Alliance**

- 1. Most Recent Audited Statements (June 30, 2013)**
- 2. Most Recent Audited Statements (June 30, 2012)**



**MOUNTAIN STATES HEALTH ALLIANCE**

**Audited Consolidated Financial Statements  
(and Other Information)**

**Years Ended June 30, 2013 and 2012**



**MOUNTAIN STATES HEALTH ALLIANCE**

***Audited Consolidated Financial Statements (and Other Information)***

***Years Ended June 30, 2013 and 2012***

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Independent Auditor's Report.....	1
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***Audited Consolidated Financial Statements***

Consolidated Balance Sheets .....	3
Consolidated Statements of Operations .....	5
Consolidated Statements of Changes in Net Assets .....	6
Consolidated Statements of Cash Flows .....	8
Notes to Consolidated Financial Statements .....	10

***Other Information***

Schedule of Expenditures of Federal and State Awards .....	44
Notes to Schedule of Expenditures of Federal and State Awards .....	47
Schedule of Prior Audit Findings .....	48
Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with <i>Government Auditing Standards</i> .....	49
Independent Auditor's Report on Compliance with Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance Required by OMB Circular A-133 .....	51
Schedule of Findings and Questioned Costs .....	53



## **INDEPENDENT AUDITOR'S REPORT**

To the Board of Directors of  
Mountain States Health Alliance:

### **Report on the Consolidated Financial Statements**

We have audited the accompanying consolidated financial statements of Mountain States Health Alliance and its subsidiaries (the Alliance), which comprise the consolidated balance sheets as of June 30, 2013 and 2012, and the related statements of operations, changes in net assets, and cash flows for the years then ended and the related notes to the consolidated financial statements.

### **Management's Responsibility for the Consolidated Financial Statements**

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

### **Auditor's Responsibility**

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Alliance's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control.

Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

### **Opinion**

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Mountain States Health Alliance and its subsidiaries as of June 30, 2013 and 2012, and the results of their operations, changes in its net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

### **Other Matters**

**Other Information:** Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal and state awards is presented for purposes of additional analysis as required by the U.S. Office of Management and Budget Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal and state awards is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

### **Other Reporting Required by Government Auditing Standards**

In accordance with *Government Auditing Standards*, we have also issued our report dated December 16, 2013 on our consideration of the Alliance's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Alliance's internal control over financial reporting and compliance.

*Pauling Yarbly: Amato PC*

Knoxville, Tennessee  
December 16, 2013

**MOUNTAIN STATES HEALTH ALLIANCE*****Consolidated Balance Sheets***  
***(Dollars in Thousands)***

	<b>June 30,</b>	
	<b>2013</b>	<b>2012</b>
<b>ASSETS</b>		
<b>CURRENT ASSETS</b>		
Cash and cash equivalents	\$ 74,902	\$ 65,107
Current portion of investments - Note C	20,386	36,557
Patient accounts receivable, less estimated allowances for uncollectible accounts of \$49,449 in 2013 and \$52,696 in 2012	164,187	147,466
Other receivables, net	33,468	30,190
Inventories and prepaid expenses	31,073	28,810
<b>TOTAL CURRENT ASSETS</b>	<b>324,016</b>	<b>308,130</b>
INVESTMENTS, less amounts required to meet current obligations	601,352	560,697
PROPERTY, PLANT AND EQUIPMENT, net	884,293	853,625
<b>OTHER ASSETS</b>		
Goodwill	154,391	154,391
Net deferred financing, acquisition costs and other charges	28,480	28,187
Other assets	46,544	39,975
<b>TOTAL OTHER ASSETS</b>	<b>229,415</b>	<b>222,553</b>
	<b>\$ 2,039,076</b>	<b>\$ 1,945,005</b>

	<i>June 30,</i>	
	<i>2013</i>	<i>2012</i>
<b>LIABILITIES AND NET ASSETS</b>		
<b>CURRENT LIABILITIES</b>		
Accrued interest payable	\$ 19,706	\$ 18,525
Current portion of long-term debt and capital lease obligations	34,417	32,477
Current portion of estimated fair value of derivatives - Note D		10,395
Accounts payable and accrued expenses	94,302	108,870
Accrued salaries, compensated absences and amounts withheld	63,665	55,589
Estimated amounts due to third-party payors, net	26,775	22,018
<b>TOTAL CURRENT LIABILITIES</b>	<b>238,865</b>	<b>247,874</b>
<b>OTHER LIABILITIES</b>		
Long-term debt and capital lease obligations, less current portion	1,090,348	1,048,098
Estimated fair value of derivatives, less current portion	8,185	8,986
Deferred revenue	2,216	3,134
Estimated professional liability self-insurance	8,758	9,344
Other long-term liabilities	17,721	16,822
<b>TOTAL LIABILITIES</b>	<b>1,366,093</b>	<b>1,334,258</b>
<b>COMMITMENTS AND CONTINGENCIES -</b>		
Notes D, F, G, and N		
<b>NET ASSETS</b>		
Unrestricted net assets		
Mountain States Health Alliance	490,414	436,388
Noncontrolling interests in subsidiaries	169,614	162,959
<b>TOTAL UNRESTRICTED NET ASSETS</b>	<b>660,028</b>	<b>599,347</b>
Temporarily restricted net assets		
Mountain States Health Alliance	12,776	11,223
Noncontrolling interests in subsidiaries	52	50
<b>TOTAL TEMPORARILY RESTRICTED NET ASSETS</b>	<b>12,828</b>	<b>11,273</b>
Permanently restricted net assets	127	127
<b>TOTAL NET ASSETS</b>	<b>672,983</b>	<b>610,747</b>
	<b>\$ 2,039,076</b>	<b>\$ 1,945,005</b>

See notes to consolidated financial statements.

**MOUNTAIN STATES HEALTH ALLIANCE*****Consolidated Statements of Operations***  
***(Dollars in Thousands)***

	<b><i>Year Ended June 30,</i></b>	
	<b><i>2013</i></b>	<b><i>2012</i></b>
<b>Revenue, gains and support:</b>		
Patient service revenue, net of contractual allowances and discounts	\$ 1,045,245	\$ 1,075,050
Provision for bad debts	(112,497)	(122,917)
Net patient service revenue	932,748	952,133
Premium revenue	1,003	-
Net investment gain	40,980	9,734
Net derivative gain	7,118	1,317
Other revenue, gains and support	77,455	50,643
<b>TOTAL REVENUE, GAINS AND SUPPORT</b>	<b>1,059,304</b>	<b>1,013,827</b>
<b>Expenses:</b>		
Salaries and wages	355,590	358,607
Physician salaries and wages	74,258	65,706
Contract labor	3,942	6,375
Employee benefits	74,590	69,600
Fees	105,891	97,959
Supplies	162,955	170,186
Utilities	16,857	17,289
Medical costs	1,039	-
Other	80,211	76,285
Loss on early extinguishment of debt - Note F	-	2,636
Depreciation	78,941	73,060
Amortization	2,260	2,245
Interest and taxes	43,203	45,903
<b>TOTAL EXPENSES</b>	<b>999,737</b>	<b>985,851</b>
<b>EXCESS OF REVENUE, GAINS AND SUPPORT OVER EXPENSES AND LOSSES</b>	<b>\$ 59,567</b>	<b>\$ 27,976</b>

*See notes to consolidated financial statements.*

**MOUNTAIN STATES HEALTH ALLIANCE****Consolidated Statements of Changes in Net Assets**  
**(Dollars in Thousands)****Year Ended June 30, 2013**

	<i>Mountain States Health Alliance</i>	<i>Noncontrolling Interests</i>	<i>Total</i>
<b>UNRESTRICTED NET ASSETS:</b>			
Excess of Revenue, Gains and Support over Expenses and Losses	\$ 52,692	\$ 6,875	\$ 59,567
Pension and other defined benefit plan adjustments	(172)	(171)	(343)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,506	-	1,506
Distributions to noncontrolling interests	-	(49)	(49)
<b>INCREASE IN UNRESTRICTED NET ASSETS</b>	<b>54,026</b>	<b>6,655</b>	<b>60,681</b>
<b>TEMPORARILY RESTRICTED NET ASSETS:</b>			
Restricted grants and contributions	4,969	21	4,990
Net assets released from restrictions	(3,416)	(19)	(3,435)
<b>INCREASE IN TEMPORARILY RESTRICTED NET ASSETS</b>	<b>1,553</b>	<b>2</b>	<b>1,555</b>
<b>INCREASE IN TOTAL NET ASSETS</b>	<b>55,579</b>	<b>6,657</b>	<b>62,236</b>
<b>NET ASSETS, BEGINNING OF YEAR</b>	<b>447,738</b>	<b>163,009</b>	<b>610,747</b>
<b>NET ASSETS, END OF YEAR</b>	<b>\$ 503,317</b>	<b>\$ 169,666</b>	<b>\$ 672,983</b>

**MOUNTAIN STATES HEALTH ALLIANCE*****Consolidated Statements of Changes in Net Assets - Continued***  
***(Dollars in Thousands)******Year Ended June 30, 2012***

	<b><i>Mountain States Health Alliance</i></b>	<b><i>Noncontrolling Interests</i></b>	<b><i>Total</i></b>
<b>UNRESTRICTED NET ASSETS:</b>			
Excess (Deficit) of Revenue, Gains and Support over Expenses and Losses	\$ 31,702	\$ (3,726)	\$ 27,976
Pension and other defined benefit plan adjustments	(1,119)	(1,115)	(2,234)
Net assets released from restrictions used for the purchase of property, plant and equipment	1,550	-	1,550
Distributions to noncontrolling interests	-	(324)	(324)
Repurchases of noncontrolling interests	3,860	(3,860)	-
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	35,993	(9,025)	26,968
<b>TEMPORARILY RESTRICTED NET ASSETS:</b>			
Restricted grants and contributions	3,860	39	3,899
Net assets released from restrictions	(3,352)	(46)	(3,398)
INCREASE (DECREASE) IN TEMPORARILY RESTRICTED NET ASSETS	508	(7)	501
INCREASE (DECREASE) IN TOTAL NET ASSETS	36,501	(9,032)	27,469
NET ASSETS, BEGINNING OF YEAR	411,237	172,041	583,278
NET ASSETS, END OF YEAR	\$ 447,738	\$ 163,009	\$ 610,747

*See notes to consolidated financial statements.*

**MOUNTAIN STATES HEALTH ALLIANCE****Consolidated Statements of Cash Flows**  
**(Dollars in Thousands)**

	<i>Year Ended June 30,</i>	
	<b>2013</b>	<b>2012</b>
<b>CASH FLOWS FROM OPERATING ACTIVITIES:</b>		
Increase in net assets	\$ 62,236	\$ 27,469
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Provision for depreciation and amortization	81,786	75,777
Provision for bad debts	112,497	122,917
Loss on early extinguishment of debt	-	2,636
Change in estimated fair value of derivatives	(457)	6,198
Equity in net income of joint ventures, net	(636)	(979)
Loss (gain) on disposal of assets	(1)	446
Amounts received on interest rate swap settlements	(6,661)	(7,515)
Gain on escrow restructuring - Note F	(13,847)	(5,337)
Gain on swap settlement - Note D	(3,020)	-
Income recognized through forward sale agreements	-	(864)
Gain on termination of swaption and forward sale agreements - Note D	-	(7,766)
Capital Appreciation Bond accretion and other	3,910	3,159
Restricted contributions	(4,990)	(3,899)
Pension and other defined benefit plan adjustments	343	2,234
Increase (decrease) in cash due to change in:		
Patient accounts receivable	(129,218)	(138,996)
Other receivables, net	(3,192)	(3,501)
Inventories and prepaid expenses	(2,263)	155
Trading securities	(17,845)	107,593
Other assets	(1,073)	(2,733)
Accrued interest payable	1,181	(1,522)
Accounts payable and accrued expenses	(20,263)	4,131
Accrued salaries, compensated absences and amounts withheld	8,076	(2,211)
Estimated amounts due to third-party payers, net	4,757	3,247
Other long-term liabilities	556	236
Estimated professional liability self-insurance	(586)	(348)
Total adjustments	9,054	153,058
<b>NET CASH PROVIDED BY OPERATING ACTIVITIES</b>	<b>71,290</b>	<b>180,527</b>
<b>CASH FLOWS FROM INVESTING ACTIVITIES:</b>		
Purchases of property, plant and equipment	(105,751)	(132,890)
Purchases of land held for expansion	(5,769)	-
Additions to goodwill	-	(5,725)
Purchases of held-to-maturity securities	(8,722)	(9,516)
Net distribution from joint ventures and unconsolidated affiliates	732	882
Proceeds from sale of property, plant and equipment	335	1,881
<b>NET CASH USED IN INVESTING ACTIVITIES</b>	<b>(119,175)</b>	<b>(145,368)</b>

	<i>Year Ended June 30,</i>	
	<i>2013</i>	<i>2012</i>
<b>CASH FLOWS FROM FINANCING ACTIVITIES:</b>		
Payments on long-term debt and capital lease obligations, including deposits to escrow	(75,066)	(71,997)
Payment of acquisition and financing costs	(2,314)	(2,742)
Proceeds from issuance of long-term debt and other financing arrangements	117,085	67,451
Payment on termination of derivative agreements - Note D	(7,375)	(93,353)
Gain on escrow restructuring - Note F	13,847	5,337
Net amounts received on interest rate swap settlements	6,661	7,515
Restricted contributions received	4,842	4,969
<b>NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES</b>	<b>57,680</b>	<b>(82,820)</b>
<b>NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS</b>	<b>9,795</b>	<b>(47,661)</b>
<b>CASH AND CASH EQUIVALENTS, beginning of year</b>	<b>65,107</b>	<b>112,768</b>
<b>CASH AND CASH EQUIVALENTS, end of year</b>	<b>\$ 74,902</b>	<b>\$ 65,107</b>

**SUPPLEMENTAL INFORMATION AND NON-CASH TRANSACTIONS:**

Cash paid for interest	<b>\$ 37,023</b>	<b>\$ 41,168</b>
Cash paid for federal and state income taxes	<b>\$ 616</b>	<b>\$ 336</b>
Construction related payables in accounts payable and accrued expenses	<b>\$ 11,598</b>	<b>\$ 6,821</b>
Property acquired through capital lease arrangement	<b>\$ -</b>	<b>\$ 13,959</b>
Payable on termination of forward sale agreements in accounts payable and accrued expenses	<b>\$ -</b>	<b>\$ 13,429</b>
Land held for expansion placed in use	<b>\$ -</b>	<b>\$ 1,610</b>

During the year ended June 30, 2012, the Alliance refinanced previously issued debt of \$174,547.

## **MOUNTAIN STATES HEALTH ALLIANCE**

### ***Notes to Consolidated Financial Statements (Dollars in Thousands)***

#### ***Years Ended 2013 and 2012***

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#### **NOTE A—ORGANIZATION AND OPERATIONS**

Mountain States Health Alliance (the Alliance) is a tax-exempt entity with operations primarily located in Washington, Sullivan, and Carter counties of Tennessee and Smyth, Wise, Dickenson, Russell and Washington counties of Virginia. The initial funds for the establishment of the Alliance in 1945 were provided by individuals and various institutions.

The primary operations of the Alliance consist of ten acute and specialty care hospitals, as follows:

- Johnson City Medical Center (JCMC) - licensed for 658 beds
- Indian Path Medical Center (IPMC) - licensed for 261 beds
- Smyth County Community Hospital (SCCH) - licensed for 153 beds
- Norton Community Hospital (NCH) - licensed for 129 beds
- Sycamore Shoals Hospital (SSH) - licensed for 121 beds
- Johnston Memorial Hospital (JMH) - licensed for 116 beds
- Franklin Woods Community Hospital (FWCH) - licensed for 80 beds
- Russell County Medical Center (RCMC) - licensed for 78 beds
- Dickenson Community Hospital (DCH) - licensed for 25 beds
- Johnson County Community Hospital (JCCH) - licensed for 2 beds

The Alliance has a 50.1% interest in JMH. JMH is also the sole member of Abingdon Physician Partners (APP), a non-taxable corporation that owns and manages physician practices.

The Alliance has a 50.1% interest in NCH. NCH is also the sole member or shareholder of DCH and Norton Community Physician Services, LLC (NCPS), a taxable corporation that consists of physician practices and a pharmacy and Community Home Care (CHC), a taxable corporation that provides home medical equipment.

The Alliance has an 80% interest in SCCH. SCCH is the sole shareholder of Southwest Community Health Services, Inc. (SWCH), a taxable entity that operates a pharmacy and provides other health services.

The activities and accounts of JMH, NCH and SCCH are included in the accompanying consolidated financial statements.

The Alliance is the sole shareholder of Blue Ridge Medical Management Corporation (BRMM), a for-profit entity that owns and manages physician practices and provides other healthcare services to patients in Tennessee and Virginia. BRMM also operates as a medical office real estate developer by owning, selling and leasing real estate to physician practices and other entities. BRMM is either the sole shareholder, a significant shareholder, or member of the following consolidated organizations:

# **MOUNTAIN STATES HEALTH ALLIANCE**

## ***Notes to Consolidated Financial Statements - Continued*** ***(Dollars in Thousands)***

### ***Years Ended 2013 and 2012***

#### **NOTE A—ORGANIZATION AND OPERATIONS - Continued**

***Mountain States Physician Group, Inc. (MSPG):*** A company that contracts with physicians to provide services to BRMM physician practices.

***Mountain States Properties, Inc. (MSPI):*** An entity that owns and manages certain real estate (primarily medical office buildings) and provides rehabilitation and fitness services.

***Mediserve Medical Equipment of Kingsport, Inc. (Mediserve):*** A company that provides durable medical equipment services.

***Kingsport Ambulatory Surgery Center (KASC) (d.b.a. Kingsport Day Surgery):*** A joint venture operating as an outpatient surgery center which performs procedures primarily in otolaryngology, orthopedics, ophthalmology, and general surgery. BRMM has a 43% ownership of KASC and maintains control over KASC through a management agreement. The accounts and activities of KASC are included in the accompanying consolidated financial statements.

***Piney Flats Urgent Care (PFUC):*** A for-profit entity that provides urgent care patient services. BRMM has a 75% ownership of PFUC. The accounts and activities of PFUC are included in the accompanying consolidated financial statements.

***Wilson Pharmacy, Inc. (Wilson):*** In August 2012, BRMM acquired Wilson, a company that owns and operates retail pharmacies. BRMM purchased 100% of the total issued and outstanding capital stock of Wilson for \$8,114 and recognized goodwill of \$5,725.

The Alliance is the primary beneficiary of the activities of Mountain States Foundation, Inc. (MSF), a not-for-profit foundation formed to coordinate fundraising and development activities of the Alliance. The Alliance is also the beneficiary of the Mountain States Health Alliance Auxiliary (Auxiliary), a not-for-profit organization formed to coordinate volunteer activities of the Alliance. The activities and accounts of MSF and the Auxiliary are included in the accompanying consolidated financial statements.

The Alliance is a 99.6% shareholder of Integrated Solutions Health Network, LLC (ISHN). The primary function of ISHN is to establish, operate and administer a provider-sponsored health care delivery network. ISHN is the sole shareholder of the following subsidiaries:

***CrestPoint Health Insurance Company (CHIC):*** A for-profit insurance company licensed in the State of Tennessee which provides network access and administration and third-party Medicare administrator services. During 2013, CHIC entered into a risk-based contract with the Center for Medicare & Medicaid Services (CMS) to provide or arrange for the provision of healthcare

# **MOUNTAIN STATES HEALTH ALLIANCE**

## ***Notes to Consolidated Financial Statements - Continued*** ***(Dollars in Thousands)***

### ***Years Ended 2013 and 2012***

#### **NOTE A—ORGANIZATION AND OPERATIONS - Continued**

services to senior citizens who have Medicare Part A, Medicare Part B and Medicare Part D entitlements.

*AnewCare Collaborative (AnewCare):* A for-profit accountable care organization which began participating in the CMS's Medicare Shared Savings Program (MSSP) in July 2012.

#### **NOTE B—SIGNIFICANT ACCOUNTING POLICIES**

***Principles of Consolidation:*** The accompanying consolidated financial statements include the accounts of the Alliance and its subsidiaries after elimination of all significant intercompany accounts and transactions.

***Noncontrolling Interests in Subsidiaries:*** The Alliance's accompanying consolidated financial statements include all assets, liabilities, revenues, expenses, and changes in net assets, including amounts attributable to the noncontrolling interests. Noncontrolling interests represent the portion of equity (net assets) in a subsidiary not attributable, directly or indirectly, to the Alliance. For the years ending June 30, 2013 and 2012, the Alliance attributed an Excess (Deficit) of Revenue, Gains and Support over Expenses and Losses of \$6,875 and (\$3,726), respectively, to the noncontrolling interests in JMH, NCH, SCCH, KASC, PFUC and ISHN based on the noncontrolling interests' respective ownership percentage.

***Use of Estimates:*** The preparation of the consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the consolidated financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results could differ from these estimates.

***Cash and Cash Equivalents:*** Cash and cash equivalents include all highly liquid investments with a maturity of three months or less when purchased. Cash and cash equivalents designated as assets limited as to use or uninvested amounts included in investment portfolios are not included as cash and cash equivalents on the Consolidated Balance Sheets.

***Investments:*** Investments as reported in the Consolidated Balance Sheets include trading securities and held-to-maturity securities (Note C). The Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) 958-320, *Investments – Debt and Equity Securities*, allows not-for-profit organizations to report in a manner similar to business entities by identifying securities as available-for-sale or held-to-maturity and to exclude the unrealized gains and losses on

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE B—SIGNIFICANT ACCOUNTING POLICIES - Continued**

those securities from the Performance Indicator (as defined below). Investments which the Alliance has the positive intent and ability to hold to maturity are considered as held-to-maturity. Substantially all other investments are considered as trading securities.

On June 30, 2013, the Alliance determined that it no longer intended to hold certain of its held-to-maturity investment portfolios to maturity and reclassified investments with an amortized cost of \$161,929 into the trading designation. As a result, the Alliance recognized net unrealized gains of approximately \$8,255 in the accompanying 2013 Consolidated Statement of Operations. The investments that remain designated as held-to-maturity are limited as to use under a safekeeping agreement or are otherwise unavailable for disposition.

Management annually evaluates investments designated as held-to-maturity and recognizes any "other-than-temporary" losses as deductions from the Performance Indicator (as defined below). Management's evaluation considers the amount of decline in fair value, as well as the time period of any such decline. Management does not believe any investment classified as held-to-maturity is other-than-temporarily impaired at June 30, 2013.

Within the trading securities portfolio, all debt securities and marketable equity securities with readily determinable fair values are reported at fair value based on quoted market prices. Investments without readily determinable fair values are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*.

Realized gains and losses are computed using the specific identification method for cost determination. Interest and dividend income is reported net of related investment fees.

Investments in joint ventures are generally reported under the equity method of accounting, which approximates the Alliance's equity in the underlying net book value, unless the ownership structure requires consolidation. Other assets include investments in joint ventures of \$2,057 and \$2,153 at June 30, 2013 and 2012, respectively. Subsequent to June 30, 2013, the Alliance liquidated a portion of its investment in one joint venture (Note S).

***Inventories:*** Inventories, consisting primarily of medical supplies, are stated at the lower of cost or market.

***Property, Plant and Equipment:*** Property, plant and equipment is stated on the basis of cost, or if donated, at the fair value at the date of gift. Generally, depreciation is computed by the straight-line method over the estimated useful life of the asset. Equipment held under capital lease obligations is

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE B—SIGNIFICANT ACCOUNTING POLICIES - Continued**

amortized under the straight-line method over the shorter of the lease term or estimated useful life. Amortization of buildings and equipment held under capital leases is shown as a part of depreciation expense and accumulated depreciation in the accompanying consolidated financial statements. Renewals and betterments are capitalized and depreciated over their useful life, whereas costs of maintenance and repairs are expensed as incurred.

Interest costs incurred on borrowed funds during the period of construction of capital assets is capitalized as a component of the cost of acquiring those assets. The amount capitalized is net of investment earnings on assets limited as to use derived from borrowings designated for capital assets.

The Alliance reviews capital assets for indications of potential impairment when there are changes in circumstances related to a specific asset. If this review indicates that the carrying value of these assets may not be recoverable, the Alliance estimates future cash flows from operations and the eventual disposition of such assets. If the sum of these undiscounted future cash flows is less than the carrying amount of the asset, a write-down to estimated fair value is recorded. The Alliance did not recognize any impairment losses during 2013 and 2012.

Other assets include property held for resale and property held for expansion of \$20,220 and \$14,451, respectively, at June 30, 2013 and 2012. Property held for resale and property held for expansion primarily represent land contributed to, or purchased by, the Alliance plus costs incurred to develop the infrastructure of such land. Management annually evaluates its investment and records non-temporary declines in value when it is determined the ultimate net realizable value is less than the recorded amount. No such declines were identified in 2013 and 2012.

**Goodwill:** Goodwill represents the difference between the acquisition cost of assets and the estimated fair value of net tangible and any separately identified intangible assets. In accordance with ASC 350, *Intangibles – Goodwill and Other*, goodwill is evaluated for impairment at least annually. The reporting unit for evaluation of the majority of the Alliance's goodwill is the aggregate acute-care operations. Management performed an evaluation of goodwill for impairment considering qualitative and quantitative factors and does not believe it is more likely than not that goodwill associated with any of its reporting units is impaired as of June 30, 2013.

**Deferred Financing, Acquisition Costs and Other Charges:** Other assets, including deferred financing, acquisition costs and other charges, total \$28,480 and \$28,187 at June 30, 2013 and 2012, respectively. Deferred financing costs are amortized over the life of the respective bond issue principally using the average bonds outstanding method. Other intangible assets include licenses and similar assets and are being amortized over the intangible's estimated useful life under the straight-line method.

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE B—SIGNIFICANT ACCOUNTING POLICIES - Continued**

Prior to 2009, the Alliance routinely financed interest rate swap and other derivative transaction issuance costs through modification of future settlement terms. As such, the unamortized issuance costs of these derivatives are included as deferred financing costs in the accompanying Consolidated Balance Sheets and are being amortized over the term of the respective derivative instrument. The unpaid issuance costs are included as a part of the estimated fair value of derivatives in the accompanying Consolidated Balance Sheets. Subsequent to 2009, interest rate swap and derivative transaction issuance costs were expensed as incurred.

***Derivative Financial Instruments:*** As further described in Note D, the Alliance is a party to various interest rate swaps. These financial instruments are not designated as hedges and have been presented at estimated fair market value in the accompanying Consolidated Balance Sheets as either current or long-term liabilities, based upon the remaining term of the instrument. Changes in the estimated fair value of these derivatives are included in the Consolidated Statements of Operations as part of net derivative gain.

***Estimated Professional Liability Self-Insurance and Other Long-Term Liabilities:*** Self-insurance liabilities include estimated reserves for reported and unreported professional liability claims (Note G) and are recorded at the estimated net present value of such claims. Other long-term liabilities include contributions payable and obligations under deferred compensation arrangements, a defined benefit pension plan, a post-retirement employee benefit plan as well as other liabilities which management estimates are not payable within one year.

***Net Patient Service Revenue/Receivables:*** Net patient service revenue is reported on the accrual basis in the period in which services are provided at the estimated net realizable amounts, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. The Alliance's revenue recognition policies related to self-pay and other types of payers emphasize revenue recognition only when collections are reasonably assured.

Patient accounts receivable are reported net of both an estimated allowance for uncollectible accounts and an estimated allowance for contractual adjustments. The contractual allowance represents the difference between established billing rates and estimated reimbursement from Medicare, Medicaid, TennCare and other third-party payment programs. Current operations include a provision for bad debts in the Consolidated Statements of Operations estimated based upon the age of the patient accounts receivable, historical writeoffs and recoveries and any unusual circumstances (such as local, regional or national economic conditions) which affect the collectibility of receivables, including management's assumptions about conditions it expects to exist and courses of action it expects to take. Additions to the allowance for uncollectible accounts result from the

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued**

provision for bad debts. Patient accounts written off as uncollectible are deducted from the allowance for uncollectible accounts.

For uninsured patients that do not qualify for charity care, the Alliance recognizes revenue on the basis of discounted rates under the Alliance's self-pay patient policy. Under the policy, a patient who has no insurance and is ineligible for any government assistance program has his or her bill reduced to the amount which generally would be billed to a commercially insured patient.

The Alliance's policy does not require collateral or other security for patient accounts receivable. The Alliance routinely accepts assignment of, or is otherwise entitled to receive, patient benefits payable under health insurance programs, plans or policies.

**Charity Care:** The Alliance accepts all patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain established policies of the Alliance and various guidelines outlined by the Federal Government. These policies define charity as those services for which no payment is anticipated and, as such, charges at established rates are not included in net patient service revenue. The estimated direct and indirect cost of providing these services totaled approximately \$24,354 and \$24,709 in 2013 and 2012, respectively. Such costs are determined using a ratio of cost to charges analysis with indirect cost allocated.

In addition to the charity care services described above, the Alliance provides a number of other services to benefit the poor for which little or no payment is received. Medicare, Medicaid, TennCare and State indigent programs do not cover the full cost of providing care to beneficiaries of those programs. The Alliance also provides services to the community at large for which it receives little or no payment.

**Excess (Deficit) of Revenue, Gains and Support Over Expenses and Losses:** The Consolidated Statements of Operations and the Consolidated Statements of Changes in Net Assets includes the caption Excess (Deficit) of Revenue, Gains and Support Over Expenses and Losses (the Performance Indicator). Changes in unrestricted net assets which are excluded from the Performance Indicator, consistent with industry practice, include contributions of long-lived assets or amounts restricted to the purchase of long-lived assets, certain pension and related adjustments, and transactions with noncontrolling interests.

**Income Taxes:** The Alliance is classified as an organization exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code. As such, no provision for income taxes has been made in the accompanying consolidated financial statements for the Alliance and its tax-exempt subsidiaries. Taxable entities account for income taxes in accordance with FASB ASC 740, *Income*

## **MOUNTAIN STATES HEALTH ALLIANCE**

### ***Notes to Consolidated Financial Statements - Continued*** ***(Dollars in Thousands)***

#### ***Years Ended 2013 and 2012***

#### **NOTE B--SIGNIFICANT ACCOUNTING POLICIES - Continued**

**Taxes (Note L).** The Alliance has no significant uncertain tax positions at June 30, 2013 and 2012. At June 30, 2013, tax returns for 2009 through 2013 are subject to examination by the Internal Revenue Service.

**Temporarily and Permanently Restricted Net Assets:** Temporarily restricted net assets are those whose use has been limited by donors to a specific time period or purpose. When a donor or time restriction expires; that is, when a stipulated time restriction ends or purpose restriction is fulfilled, temporarily restricted net assets are reclassified as unrestricted net assets and reported in the Consolidated Statements of Operations and Changes in Net Assets as net assets released from restrictions. The Alliance's policy is to net contribution and grant revenues against related expenses and present such amounts as a part of other revenue, gains and support in the Consolidated Statements of Operations. Permanently restricted net assets have been restricted by donors to be maintained by the Alliance in perpetuity.

**Premium Revenue:** Premiums earned include premiums from individuals and Medicare. Medicare revenue includes premiums based on predetermined prepaid rates under Medicare risk contracts. Premiums are recognized in the month in which the members are entitled to health care services. Premiums collected in advance are deferred and recorded as unearned premium revenue. Premium deficiency losses are recognized when it is probable that expected future claim expenses will exceed future premiums on existing contracts. CHIC evaluated the need for a premium deficiency reserve and recorded an estimated reserve of \$1,500 at June 30, 2013.

**Medicare Shared Savings Program (MSSP):** AnewCare, an Accountable Care Organization (ACO), participates in CMS's Medicare Shared Savings Program which is designed to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. ACOs participating in the program are assigned beneficiaries by CMS and are entitled to share in the savings if they are able to lower growth in Medicare Parts A and B fee-for-service costs while meeting performance standards on quality of care. The program is based on performance periods, the first of which specific to AnewCare is the period of July 2012 to December 2013. Utilizing statistical data and the methodology employed by CMS, AnewCare has estimated and recognized \$2,644 of net shared savings through June 30, 2013. Variability is inherent in the estimation methodology and due to uncertainties in the estimation; it is probable that management's estimates of shared savings, if any, will change by the end of the performance period, and such change could be significant.

**Electronic Health Record Incentives:** The American Recovery and Reinvestment Act of 2009 (ARRA) provides for incentive payments under the Medicare and Medicaid programs for certain hospitals and physician practices that demonstrate meaningful use of certified electronic health

## MOUNTAIN STATES HEALTH ALLIANCE

### *Notes to Consolidated Financial Statements - Continued* (Dollars in Thousands)

#### *Years Ended 2013 and 2012*

#### NOTE B—SIGNIFICANT ACCOUNTING POLICIES - Continued

record (EHR) technology. The incentive payments are calculated based upon estimated discharges, charity care and other input data and are predicated upon the Alliance's attainment of program and attestation criteria and are subject to regulatory audit. During the years ending June 30, 2013 and 2012, the Alliance recognized EHR incentive revenues of \$22,474 and \$4,894, respectively, comprised of \$17,340 of Medicare revenues in 2013 and \$5,134 and \$4,894 of Medicaid revenues in 2013 and 2012, respectively. EHR incentive revenues are included in other revenue, gains and support in the accompanying Consolidated Statements of Operations.

The Alliance incurs both capital expenditures and operating expenses in connection with the implementation of its various EHR initiatives. The amount and timing of these expenditures does not directly correlate with the timing of the Alliance's receipt or recognition of the EHR incentive payments.

**Medical Costs:** The cost of health care services is recognized in the period in which services are provided. Medical costs include an estimate of the cost of services provided to CHIC members by third-party providers, which have been incurred but not provided to CHIC. The estimate for incurred but not reported claims is based on actuarial projections of costs using historical paid claims and industry data. Due to uncertainties in the estimation, it is at least reasonably possible that management's estimates of incurred but not reported claims will change in 2014, although the amount of the change cannot be estimated.

**Fair Value Measurement:** The Alliance had previously adopted FASB ASC 820, *Fair Value Measurements and Disclosures*, which defines fair value, establishes a framework for measuring fair value under generally accepted accounting principles and expands disclosures about fair value measurements.

**Subsequent Events:** The Alliance evaluated all events or transactions that occurred after June 30, 2013, through December 16, 2013, the date the consolidated financial statements were available to be issued. During this period management did not note any material recognizable subsequent events that required recognition or disclosure in the June 30, 2013 consolidated financial statements, other than as discussed in Note S.

**Reclassifications:** Certain 2012 amounts have been reclassified to conform with the 2013 presentation in the accompanying consolidated financial statements. Prior to 2013, the Alliance classified only those activities directly associated with its mission of providing healthcare services, as well as other activities deemed significant to its operations, as operating activities. In 2013, the Alliance no longer presents an intermediate measure of operating income (loss) and the 2012 Consolidated Statement of Operations has been reformatted to be consistent with this presentation.

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE C—INVESTMENTS**

Assets limited as to use are summarized by designation or restriction as follows at June 30:

	<b>2013</b>	<b>2012</b>
Designated or restricted:		
Under safekeeping agreements and other	\$ 10,350	\$ 24,026
By Board for capital improvements	-	4
Under bond indenture agreements:		
For debt service and interest payments	60,823	77,602
For capital acquisitions	36,989	29,578
	108,162	131,210
Less: amount required to meet current obligations	(20,386)	(36,557)
	<b>\$ 87,776</b>	<b>\$ 94,653</b>

Assets limited as to use consist of the following at June 30:

	<b>2013</b>	<b>2012</b>
Cash, cash equivalents and money market funds	\$ 57,190	\$ 80,304
U.S. Government securities	11,164	8,582
U.S. Agency securities	30,407	40,398
Corporate and foreign bonds	7,530	-
Municipal obligations	1,871	1,926
	<b>\$ 108,162</b>	<b>\$ 131,210</b>

Trading securities consist of the following at June 30:

	<b>2013</b>	<b>2012</b>
Cash, cash equivalents and money market funds	\$ 9,488	\$ 5,186
U.S. Government securities	18,481	10,697
U.S. Agency securities	19,620	26,165
Corporate and foreign bonds	172,350	52,581
Municipal obligations	17,749	961
Preferred and asset backed securities	3,491	11,183
U.S. equity securities	10,944	28,344
Mutual funds	186,028	141,968
Other	37,353	34,880
	<b>\$ 475,504</b>	<b>\$ 311,965</b>

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE C--INVESTMENTS - Continued**

Held-to-maturity securities (other than assets limited as to use) are carried at amortized cost and consist of the following at June 30:

	<b>2013</b>	<b>2012</b>
Cash, cash equivalents and money market funds	\$ 75	\$ 298
Corporate and foreign bonds	33,060	138,232
Municipal obligations	4,937	15,549
	<b>\$ 38,072</b>	<b>\$ 154,079</b>

Held-to-maturity securities had gross unrealized gains and losses of \$15 and \$1,421, respectively, at June 30, 2013 and \$11,432 and \$33, respectively at June 30, 2012. At June 30, 2013 and 2012, the Alliance held no securities within the held-to-maturity portfolio which had been at an unrealized loss position for over one year. At June 30, 2013, the contractual maturities of held-to-maturity securities were \$2,702 due in one year or less, \$17,923 due from one to five years and \$17,447 due after five years. At June 30, 2012, the contractual maturities of held-to-maturity securities were \$11,225 due in one year or less, \$67,532 due from one to five years and \$75,322 due after five years.

The net investment gain is comprised of the following for the years ending June 30:

	<b>2013</b>	<b>2012</b>
Interest and dividend income, net of fees	\$ 13,881	\$ 15,213
Net realized (losses) gains on the sale of securities	3,074	(2,595)
Change in net unrealized gains on securities	24,025	(2,884)
	<b>\$ 40,980</b>	<b>\$ 9,734</b>

At June 30, 2013 and 2012, the Alliance held investments in certain limited partnerships and hedge funds with a recorded value of \$37,353 and \$34,880, respectively, that have a wide range of investment strategies with various levels of risk. These funds are included within trading securities and do not have readily determinable fair values. The funds are reported at estimated fair market value pursuant to FASB ASC 825, *Financial Instruments*.

**NOTE D--DERIVATIVE TRANSACTIONS**

The Alliance is a party to a number of derivative transactions. These derivatives have not been designated as hedges and are valued at estimated fair value in the accompanying Consolidated Balance Sheets. Management's primary objective in holding such derivatives is to introduce a

## MOUNTAIN STATES HEALTH ALLIANCE

Notes to Consolidated Financial Statements - Continued  
(Dollars in Thousands)

## Years Ended 2013 and 2012

## NOTE D—DERIVATIVE TRANSACTIONS - Continued

variable rate component into its fixed rate debt structure. Under the terms of these agreements, changes in the interest rate environment could have a significant effect on the Alliance. Deferred financing and acquisition costs, net of amortization, include \$5,791 and \$6,135 at June 30, 2013 and 2012, respectively, related to these swaps.

These derivative agreements require that the Alliance post additional collateral for the derivatives' fair market value deficits above specified levels. As of June 30, 2013, the Alliance was not required to post additional collateral. Such investments totaling \$13,809 are included as assets limited as to use in the accompanying 2012 Consolidated Balance Sheet.

The following is a summary of the interest rate swap agreements at June 30, 2013 and 2012:

Notional Amount	Term	Counterparty	Payments by:		Estimated Fair Value	
			Receive	Pay	2013	2012
\$ 170,000	4/2008-4/2026	Bank of America, Merrill Lynch	1.27% 7/2012-4/2013 1.07% 5/2013-6/2013	0.00%	\$ 3,895	\$ 3,500
95,000	4/2008-4/2026	Bank of America, Merrill Lynch	1.27% 7/2012-4/2013 1.08% 5/2013-6/2013	0.00%	2,205	1,983
173,030	4/2008-4/2034	Bank of America, Merrill Lynch	1.32% 7/2012-4/2013 1.12% 5/2013-6/2013	0.00%	(710)	(513)
82,055	12/2007-7/2033	Bank of America, Merrill Lynch	67% USD-LIBOR-BBA	0.312% + USD-SIFMA	(9,322)	(9,520)
50,000	2/2008-7/2038	Bank of America, Merrill Lynch	67% (USD-LIBOR-BBA + 0.15%)	USD-SIFMA	(4,218)	(3,895)
21,400	7/2007-7/2015	Bank of America, Merrill Lynch	1.05% + USD-SIFMA	4.50%	35	(320)
5,524	Various	Various	Various	Various	(70)	(221)
					<u>\$ (8,185)</u>	<u>\$ (8,986)</u>

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE D—DERIVATIVE TRANSACTIONS - Continued**

The terms of five of these agreements were modified without settlement during 2013. No gain or loss was realized as a result of the modifications although such modifications did impact the estimated fair value of the interest rate swaps as of June 30, 2013.

The net investment derivative gain is comprised of the following for the years ending June 30:

	<b>2013</b>	<b>2012</b>
Settlement income and other	\$ 6,661	\$ 7,515
Change in estimated fair value	457	(6,198)
	<u>\$ 7,118</u>	<u>\$ 1,317</u>

These fair values are based on the estimated amount the Alliance would receive, or be required to pay, to enter into equivalent agreements at the valuation date and include an estimated credit value adjustment. The fair value of various derivatives are netted on the Consolidated Balance Sheets based on management's evaluation of the settlement provisions in the master contract. Gross positions of these derivatives are indicated in the table above. Due to the nature of these financial instruments, such estimates of fair value are subject to significant change in the near term.

The Alliance was previously a party to a total return swap with Lehman Brothers as the counterparty. Lehman Brothers filed for bankruptcy in September 2008. The Alliance subsequently received notification from Lehman Brothers Special Financing, Inc. indicating the intent of the counterparty to terminate this agreement effective January 1, 2009. The Alliance and Lehman Brothers Special Financing, Inc. were unable to reach a settlement agreement at the time the swap was terminated. An estimated liability related to the agreement of \$10,395 was recognized by the Alliance at June 30, 2012. In addition, a third party held investments with a fair market value of approximately \$13,809, at June 30, 2012, as collateral. In 2013, the parties reached a settlement agreement and in full settlement of the liability, the Alliance paid the counterparty \$7,375 from the funds held as collateral and the remaining collateral was returned to the Alliance. A gain of approximately \$3,020 was recognized on the settlement, which is included within other revenue, gains and support in the accompanying 2013 Consolidated Statement of Operations.

In June 2004, the Alliance entered into an agreement with Bear Stearns (acquired by JP Morgan) whereby Bear Stearns purchased from the Alliance an option to enter into an interest rate swap agreement (swaption) with the Alliance beginning July 1, 2011. During 2012, the counterparty expressed their intent to exercise the swaption on January 1, 2012 and the Alliance exercised its right to terminate the swaption at its fair market value. To effectuate the termination, the Alliance transferred \$93,353 of a Guaranteed Investment Contract (GIC), to the third party as a termination payment. A gain of \$3,058 was recognized on the termination, which is included within other

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE D--DERIVATIVE TRANSACTIONS - Continued**

revenue, gains and support in the accompanying 2012 Consolidated Statement of Operations. Net derivative gain in the accompanying 2012 Consolidated Statement of Operations includes an unrealized loss of \$4,676 related to this derivative, prior to termination.

Also in June 2004, the Alliance entered into two related forward sale agreements with the counterparty to the swaption agreements and the Master Trustee of the Series 2000 Bonds. In June 2012, the Alliance and the counterparty terminated the agreements. To effectuate the termination, the Alliance agreed to pay \$13,429 to the counterparty. The termination payable is included in accounts payable and accrued expenses in the accompanying 2012 Consolidated Balance Sheet. The Alliance recognized a gain of \$4,708 on the termination of these agreements, which is included within other revenue, gains and support in the accompanying 2012 Consolidated Statement of Operations.

**NOTE E--PROPERTY, PLANT AND EQUIPMENT**

Property, plant and equipment consist of the following at June 30:

	<b>2013</b>	<b>2012</b>
Land	\$ 60,180	\$ 57,525
Buildings and leasehold improvements	718,489	661,146
Property and improvements held for leasing	77,767	74,914
Equipment	664,469	571,774
Buildings and equipment held under capital lease	671	20,540
	<u>1,521,576</u>	<u>1,385,899</u>
Less: Allowances for depreciation and amortization	(704,002)	(626,552)
	817,574	759,347
Construction in progress (Note N)	66,719	94,278
	<u>\$ 884,293</u>	<u>\$ 853,625</u>

Accumulated depreciation and amortization on property and improvements held for leasing purposes is \$25,146 and \$22,951 at June 30, 2013 and 2012, respectively. Net interest capitalized was \$4,163 and \$3,110 for the years ended June 30, 2013 and 2012, respectively.

During 2012, the Alliance executed an Amendment and Mutual Release Agreement with a vendor whereby the Alliance waived its right to take any action with respect to prior contracts in exchange for professional services in future periods, primarily related to accelerated deployment of information

# MOUNTAIN STATES HEALTH ALLIANCE

## Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

### Years Ended 2013 and 2012

#### NOTE E--PROPERTY, PLANT AND EQUIPMENT - Continued

systems. The Alliance recognized approximately \$3,386 and \$3,799 in 2013 and 2012 as additions to property, plant and equipment with an offsetting gain related to the agreed-upon value of such professional services. The Alliance anticipates recognition of additional amounts in future periods as such services are provided.

#### NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS

Long-term debt and capital lease obligations consist of the following at June 30:

Description	Maturities	Rates	Outstanding Balance	
			2013	2012
2012A Hospital Revenue Bonds, net of unamortized premium of \$1,817 at June 30, 2013	\$55,000 uninsured term bonds, due August 15, 2042, subject to early redemption	5.00%	\$ 56,817	\$
2012B Hospital Revenue Bonds	\$28,095 uninsured term bonds, due August 15, 2042, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	28,095	
2012C Hospital Revenue Bonds	\$9,785 uninsured term bonds, due August 15, 2042, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	9,785	
2011A Hospital Revenue Bonds	\$61,185 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	61,185	65,260
2011B Hospital Revenue Bonds	\$20,000 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	20,000	20,000
2011C Hospital Revenue Bonds	\$48,974 uninsured term bonds, due July 1, 2031, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	48,974	49,875
2011D Hospital Revenue Bonds	\$60,705 uninsured term bonds, due July 1, 2031, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	60,705	60,705
2011E Taxable Bonds	\$15,960 uninsured term bonds, due July 1, 2026, subject to early redemption or tender	Variable, 0.17% at June 30, 2013	15,960	15,960
2011 Hospital Facility Revenue Refunding and Improvement Bonds (JMH)	\$23,095 uninsured term bonds, due July 1, 2033, subject to early redemption or tender	Variable, 1.14% at June 30, 2013	23,095	24,870
2010A Hospital Revenue Bonds, net of unamortized premium of \$978 and \$1,017 at June 30, 2013 and 2012, respectively	\$28,780 uninsured serially, through 2020 \$14,985 uninsured term bonds, due July 1, 2025 \$19,230 uninsured term bonds, due July 1, 2030 \$39,570 uninsured term bonds, due July 1, 2038 \$55,480 uninsured term bonds, due July 1, 2038	3.00% to 5.00% 5.38% 5.63% 6.50% 6.00%	159,023	162,952
2010B Hospital Revenue Bonds, net of unamortized premium of \$626 and \$669 at June 30, 2013 and 2012, respectively	\$20,295 uninsured serially, through 2020 \$4,355 uninsured term bonds, due July 1, 2023 \$4,250 uninsured term bonds, due July 1, 2028	2.50% to 5.00% 5.00% 5.50%	29,526	33,129
2009A Hospital Revenue Bonds, net of unamortized discount of \$113 and \$117 at June 30, 2013 and 2012, respectively	\$655 uninsured term bonds, due July 1, 2019 \$1,730 uninsured term bonds, due July 1, 2029 \$3,105 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	5,377	5,443
2009B Hospital Revenue Bonds	\$5,470 uninsured term bonds, due July 1, 2038	8.00%	5,470	5,535
2009C Hospital Revenue Bonds, net of unamortized discount of \$2,246 and \$2,334 at June 30, 2013 and 2012, respectively	\$18,800 uninsured term bonds, due July 1, 2019 \$20,000 uninsured term bonds, due July 1, 2029 \$74,855 uninsured term bonds, due July 1, 2038	7.25% 7.50% 7.75%	111,409	113,621
2008A Hospital Revenue Bonds	\$13,245 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	13,245	13,245
2008B Hospital Revenue Bonds	\$51,965 uninsured term bonds, due July 1, 2038, subject to early redemption or tender	Variable, 0.06% at June 30, 2013	51,965	52,930
2007B Taxable Hospital Revenue Bonds, sub-series B-1 and B-2	\$123,335 uninsured term bonds, due July 1, 2033, subject to early redemption or tender, sub-series B-3 redeemed in 2013	Variable, 0.17% to 0.18% at June 30, 2013	123,335	156,760

# MOUNTAIN STATES HEALTH ALLIANCE

## Notes to Consolidated Financial Statements - Continued (Dollars in Thousands)

### Years Ended 2013 and 2012

#### NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued

Description	Maturities	Rate	Outstanding Balance	
			2013	2012
2006A Hospital First Mortgage Revenue Bonds, net of unamortized premium of \$135 and \$141 at June 30, 2013 and 2012, respectively	\$5,295 uninsured serially, through 2019 \$7,375 uninsured term bonds, due July 1, 2026 \$20,505 uninsured term bonds, due July 1, 2031 \$135,175 uninsured term bonds, due July 1, 2036	5.00% 5.25% 5.50% 5.50%	168,485	169,136
2001A Hospital First Mortgage Revenue Bonds	\$21,400 term bonds, due July 1, 2026, subject to early redemption or tender	4.50%	21,400	22,300
2000A Hospital First Mortgage Revenue Refunding Bonds	\$34,645 Insured Capital Appreciation Bonds, interest and principal due July 1, 2026 through 2030	6.63%	34,645	32,431
2000C Hospital First Mortgage Revenue Bonds	\$32,040 insured term bonds, due July 1, 2026	8.50%	32,040	33,230
2000D First Mortgage Taxable Bonds	\$13,800 insured term bonds, due July 1, 2026	8.50%	13,800	14,315
Capitalized lease obligations secured by equipment	Various monthly payments of principal and interest	Various	1,240	1,645
\$1,593 note payable, secured by equipment	Various annual principal payments through July 2014	Unspecified	896	1,343
Capitalized lease obligation secured by medical office building (IMH)	Lease was paid-off in 2013	N/A	-	15,498
Master installment payment agreement	Various quarterly payments through May 2014	Unspecified	2,320	4,438
Master installment payment agreement, secured by equipment	Various quarterly payments through May 2014	Unspecified	1,503	3,032
\$1,640 note payable, secured by land	Monthly principal payments of \$10 through maturity in July 2015	Unspecified	1,640	1,870
\$985 in promissory notes secured by assets of Humana Community Healthcare, LLC	Various monthly principal and interest payments through 2019	3.80% - 3.75%	985	1,052
\$17,607 term note	Monthly principal and interest payments of \$60 beginning November 2012 maturing September 2015; remaining principal due October 2015	Variable, 1.14% at June 30, 2013	17,607	-
\$4,238 in notes payable, secured by land	Annual principal payments of \$215 beginning October 2013 maturing October 2015; remaining principal due October 2016. Interest is payable monthly.	Variable, 0.19% at June 30, 2013	4,238	-
Less current portion			1,124,765 (34,417)	1,080,575 (32,477)
			\$ 1,090,348	\$ 1,048,098

**Series 2012 Bonds:** In September 2012, the Alliance issued \$55,000 (Series 2012A) fixed rate and \$28,095 (Series 2012B) variable rate tax-exempt Hospital Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee, and \$9,785 (Series 2012C) variable rate tax-exempt Hospital Revenue Bonds through the Industrial Development Authority of Wise, Virginia (collectively, the Series 2012 Bonds). The proceeds from the Series 2012A Bonds will be used to finance a surgery center project at JCMC and pay issuance costs related to these Bonds. The proceeds from the Series 2012B and 2012C Bonds will be used to finance or refinance capital improvements and equipment acquisitions and to pay issuance costs associated with these Bonds. The timely payment of the Series 2012B and Series 2012C Bonds is secured by irrevocable transferable direct-pay letters of credit which expire September 17, 2015.

**Series 2011 Bonds:** In October 2011, the Alliance issued \$65,260 (Series 2011A) and \$20,000 (Series 2011B) variable rate tax-exempt Hospital Revenue Bonds through The Health and

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE F—LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued**

Educational Facilities Board of the City of Johnson City, Tennessee, \$49,875 (Series 2011C) and \$60,705 (Series 2011D) variable rate tax-exempt Hospital Revenue Bonds through the Industrial Development Authority of Smyth, Virginia and \$15,960 (Series 2011E) variable rate Taxable Bonds (collectively, the Series 2011 Bonds). The proceeds from the Series 2011A and Series 2011B Bonds were used to finance certain capital acquisitions in the State of Tennessee and pay issuance costs related to these Bonds. The proceeds from the Series 2011C and 2011D Bonds were used to refinance the 2001 NCH Hospital Refunding and Improvement Revenue Bonds, finance capital acquisitions for NCH, JMH and SCCH and to pay issuance costs associated with these Bonds. The Series 2011E Bond proceeds were used to refinance certain capital acquisitions of SCCH and BRMM and pay issuance costs. The timely payment of the Series 2011 Bonds is secured by a letter of credit which expires October 19, 2014.

In November 2011, JMH issued \$24,870 (JMH Series 2011) variable rate tax-exempt Hospital Facility Revenue Refunding and Improvement Bonds through the Industrial Development Authority of Smyth County. The proceeds from the JMH Series 2011 Bonds were used to refinance the 1998 Hospital Refunding and Improvement Revenue Bonds, refinance existing indebtedness incurred to finance capital acquisitions and to pay issuance costs associated with the Bonds.

**Series 2010 Bonds:** In April 2010, the Alliance issued \$168,080 (Series 2010A) and \$35,935 (Series 2010B) fixed rate Hospital Refunding Revenue Bonds (collectively, the Series 2010 Bonds). Proceeds of the Series 2010A and the Series 2010B Bonds were used to refinance outstanding indebtedness, specifically related to the Alliance's facilities in Tennessee and in Virginia, respectively, fund debt service reserve funds and pay costs of issuance.

**Series 2009 Bonds:** In March 2009, the Alliance issued \$5,560 (Series 2009A), \$5,535 (Series 2009B) and \$115,955 (Series 2009C) fixed rate Hospital Revenue Bonds (collectively, the Series 2009 Bonds). The proceeds of Series 2009 Bonds were used to refinance a portion of the outstanding Series 2006C Taxable Notes, which were originally issued to finance a capital commitment to SCCH and purchase certain leased assets, finance the acquisition of a majority ownership in JMH, fund a debt service reserve fund and pay costs of issuance. The portion of the 2006C taxable notes which were not refinanced with the Series 2009 Bonds were repaid with cash on hand.

**Series 2008 Bonds:** In February 2008, the Alliance issued \$72,770 (Series 2008A) and \$54,230 (Series 2008B) variable rate Hospital Revenue Bonds (collectively, the Series 2008 Bonds). The proceeds of Series 2008 Bonds were primarily used to finance certain future capital projects for the Alliance's hospital facilities and for the repayment of previously issued 2008 Taxable Notes used for the acquisition of RCMC. The payment of principal and interest on the Series 2008 Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable,

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued**

transferable, direct-pay letter of credit. A portion (\$59,525) of the Series 2008A Bonds were repaid from proceeds of the Series 2010 Bonds.

**Series 2007 Bonds:** In December 2007, the Alliance issued \$104,355 (Series 2007A), \$327,170 (Series 2007B taxable) and \$36,575 (Series 2007C) variable rate Hospital Revenue Bonds (collectively, the Series 2007 Bonds). The proceeds of Series 2007 Bonds were primarily used to early extinguish a portion of the outstanding Series 2000A Bonds, all of the outstanding 2000B Bonds, all of the outstanding Series 1994 Bonds, and all of the outstanding Series 2006B Bonds; to finance the acquisition of a majority ownership in NCH, and to finance certain capital improvements and equipment acquisitions for the Alliance's hospital facilities. A portion of the outstanding Series 2007A (\$91,685) and Series 2007C (\$32,840) Bonds were repaid from proceeds of the Series 2010 Bonds.

During 2012, the Alliance redeemed \$115,135 of the Series 2007B-1 Bonds and \$29,405 of the Series 2007B-3 Bonds. The Alliance redeemed \$26,530 of the Series 2007B-3 Bonds during 2013. The payment of principal and interest on the outstanding Sub-Series 2007B Bonds and the purchase price of any tendered bonds on each series are secured by a separate, irrevocable, transferable, direct-pay letter of credit.

**Series 2006 Bonds:** During 2006, the Alliance issued \$173,030 Hospital First Mortgage Revenue Bonds (Series 2006A) and \$66,500 Hospital First Mortgage Variable Rate Revenue Bonds (Series 2006B). The proceeds from the sale of the Series 2006A Bonds were used to finance certain future and prior capital projects for the Alliance's hospital facilities and to refund certain existing indebtedness, specifically the Series 2001B Bonds (discussed below) and certain existing short and intermediate term loans and leases, as well as fund a debt service reserve fund. The Series 2006B Bond proceeds were substantially used to refund the remaining outstanding principal of the Series 2001B Bonds and establish a debt service reserve fund.

**Series 2001 Bonds:** During 2001, the Alliance issued \$26,000 Hospital First Mortgage Revenue Bonds (Series 2001A). The Alliance redeemed the 2001A Bonds and released a new Series 2001A to Bank of America Merrill Lynch during 2012.

**Series 2000 Bonds:** The Hospital First Mortgage Revenue Refunding (Series 2000A Bonds) and First Mortgage Revenue Refunding Bonds (Series 2000B Bonds), were used to advance refund previously existing indebtedness as well as fund a required debt service reserve fund. The Hospital First Mortgage Revenue Bonds (Series 2000C Taxable Bonds) were used to refinance certain mortgage indebtedness of BRMM, and to refund other previously existing indebtedness. The

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE F--LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued**

proceeds from the sale of the First Mortgage Bonds (Series 2000D Taxable Bonds) were used primarily to fund working capital for the Alliance.

The Series 2000A Bonds included at issue date \$14,680 of insured Capital Appreciation Bonds. Such bonds bear a 0% coupon rate and have a yield of 6.625% annually. The Alliance recognizes interest expense and increases the amount of outstanding debt each year based upon this yield. Total principal and interest due at maturity (2026 through 2030) is \$93,675.

*Derecognized Bonds:* The advance refunding of previously issued debt requires funds to be placed in irrevocable trusts in order to satisfy remaining scheduled principal and interest payments. Management, upon advice of legal counsel, believes the amounts deposited in such irrevocable trust accounts have contractually relieved the Alliance of any future obligations with respect to this debt, and the debt and escrowed securities are not considered liabilities or assets of the Alliance. Therefore, such debt has been derecognized. Debt outstanding and not recognized in the Consolidated Balance Sheet at June 30, 2013 due to previous advance refundings of the Series 2000A Bonds, Series 2000B Bonds, Series 1998C Bonds, and Series 1991 Bonds, totaled approximately \$213,060.

The assets placed in the irrevocable trust accounts are also not recognized as assets of the Alliance. These assets consist primarily of various investments, as permitted by bond indentures and other documents, including United States Treasury obligations, an investment contract with MBIA Insurance Corporation (MBIA) in the original amount of \$54,300, as well as the Series 2000C and 2000D Bonds which were purchased with the proceeds of the 2000A and 2000B Bonds specifically for the purpose of utilizing the Series 2000C and 2000D Bonds in the irrevocable trust. Therefore, certain of the assets held in the irrevocable trust accounts have future income streams contingent upon payments by the Alliance.

The Alliance instructed the trustee of the 1998C Bonds to liquidate certain investments held in the related irrevocable trust account and to redeem a portion of the 1998C Bonds with the proceeds from the liquidation. The fair value of the liquidated assets exceeded the payment necessary to redeem the 1998C Bonds and the excess was paid to the Alliance. As a result of this transaction, the Alliance recognized a net gain in 2013 and 2012 of \$13,847 and \$5,337, respectively, which is included in other revenue, gains and support in the accompanying Consolidated Statements of Operations.

*Variable Rate Issuances:* The variable rate of interest on the Series 2012, Series 2011, Series 2008 and Series 2007 Bonds is determined weekly by the Remarketing Agent, as the rate equal to the lowest rate which, in regard to general financial conditions and other special conditions bearing on the rate, would produce as nearly as possible a par bid for the Bonds in the secondary market. In no

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE F—LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued**

event shall the variable rate on the Bonds during any period where interest is calculated weekly exceed the lesser of 12% annually or the maximum contract rate of interest permitted by the applicable State of issue. The Alliance has the option, upon written approval of the holder of the letters of credit, the Remarketing Agent and others, to convert to a medium-term rate period or to a fixed rate.

**Early Redemption:** Essentially all of the Alliance's bonds are subject to redemption prior to maturity, including optional, mandatory sinking fund and extraordinary redemption, at various dates and prices as described in the respective Bond indentures and other documents.

**Other Bonds, Notes Payable and Financing Arrangements:** The Alliance has granted a deed of trust on JCMC and SSH to secure the payment of the outstanding Bonds. The Bonds are also secured by the Alliance's receivables, inventories and other assets as well as certain funds held under the documents pursuant to which the bonds were issued. The JMH Series 2011 Hospital Refunding and Improvement Revenue Bonds are secured by pledged revenues of JMH, as defined in the Credit Agreement.

The scheduled maturities and mandatory sinking fund payments of the long-term debt and capital lease obligations (excluding interest), exclusive of net unamortized original issue discount and premium, at June 30, 2013 are as follows:

<u>Year Ending June 30,</u>	
2014	\$ 34,417
2015	28,191
2016	45,427
2017	32,290
2018	29,253
Thereafter	<u>953,990</u>
	1,123,568
Net premium	<u>1,197</u>
	<u>\$ 1,124,765</u>

Certain members of the Alliance and JMH are each members of separate Obligated Groups. The bond indentures, master trust indentures, letter of credit agreements and loan agreements related to the various bond issues and notes payable contain covenants with which the respective Obligated Groups must comply. These requirements include maintenance of certain financial and liquidity ratios, deposits to trustee funds, permitted indebtedness, use of facilities and disposals of property.

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE F—LONG-TERM DEBT AND OTHER FINANCING ARRANGEMENTS - Continued**

These covenants also require that failure to meet certain debt service coverage tests will require the deposit of all daily cash receipts of the Alliance into a trust fund. Management has represented the Alliance and JMH are in compliance with all such covenants at June 30, 2013.

In connection with the tax-exempt bonds, the Alliance is required every five years, and at maturity, to remit to the Internal Revenue Service amounts which are due related to positive arbitrage on the borrowed funds. The Alliance performs such computations when required and recognizes any liability at that time. Management does not believe there are any significant arbitrage liabilities at June 30, 2013 or 2012.

During 2012, the Alliance recognized a \$2,636 loss on early extinguishment of debt representing the write off of previously deferred and unamortized financing costs generally related to the refinanced or otherwise redeemed portion of the Series 2007B Bonds, Series 1998 JMH Bonds and the Series 2001 NCH Bonds.

**NOTE G—SELF-INSURANCE PROGRAMS**

The Alliance is substantially self-insured for professional and general liability claims and related expenses. The Alliance maintains a \$25,000 umbrella liability policy that attaches over the self-insurance limits of \$10,000 per claim and a \$15,000 annual aggregate retention. The Alliance's insurance program also provides professional liability coverage for certain affiliates and joint ventures.

The Alliance is also substantially self-insured for workers' compensation claims in the State of Tennessee and has established estimated liabilities for both reported and unreported claims. The Alliance maintains a stop-loss policy that attaches over the self-insurance limits of \$1,000 per occurrence and \$1,000 annual aggregate retention. In the State of Virginia, the Alliance is not self-insured and maintains workers' compensation insurance through commercial carriers.

At June 30, 2013, the Alliance is involved in litigation relating to medical malpractice and workers' compensation and other claims arising in the ordinary course of business. There are also known incidents occurring through June 30, 2013 that may result in the assertion of additional claims, and other unreported claims may be asserted arising from services provided in the past. Alliance management has estimated and accrued for the cost of these unreported claims based on historical data and actuarial projections. The estimated net present value of malpractice and workers' compensation claims, both reported and unreported, as of June 30, 2013 and 2012 was \$12,348 and \$12,896, respectively. The discount rate utilized was 5% at June 30, 2013 and 2012.

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE G—SELF-INSURANCE PROGRAMS - Continued**

Additionally, the Alliance is self-insured for employee health claims and recognizes expense each year based upon actual claims paid and an estimate of claims incurred but not yet paid, including a catastrophic claims reserve based on historical claims in excess of \$75. Such amount is included in accounts payable and accrued expenses in the Consolidated Balance Sheets.

**NOTE H—NET PATIENT SERVICE REVENUE**

A reconciliation of the amount of services provided to patients at established rates to net patient service revenue as presented in the accompanying Consolidated Statements of Operations is as follows for the years ended June 30:

	<b>2013</b>	<b>2012</b>
Inpatient service charges	\$ 2,086,519	\$ 2,095,036
Outpatient service charges	2,120,400	1,982,154
Gross patient service charges	4,206,919	4,077,190
Less:		
Estimated contractual adjustments and other discounts	3,058,580	2,899,678
Charity care	103,094	102,462
Provision for bad debts	112,497	122,917
	3,274,171	3,125,057
Net patient service revenue	\$ 932,748	\$ 952,133

Patient service revenue, net of contractual allowances and discounts is composed of the following for the years ended June 30:

	<b>2013</b>	<b>2012</b>
Third-party payers	946,979	\$ 968,101
Patients	98,266	106,949
Patient service revenue	\$ 1,045,245	\$ 1,075,050

Patient deductibles and copayments under third-party payment programs are included within the patient amounts above.

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE H--NET PATIENT SERVICE REVENUE - Continued**

Management regularly reviews data about these major payer sources of revenue in evaluating the sufficiency of the allowance for uncollectible accounts. For receivables associated with services provided to patients who have third-party coverage, the Alliance analyzes contractually due amounts and provides an allowance for uncollectible accounts and a provision for bad debts, if necessary, for expected uncollectible deductibles and copayments on accounts for which the third-party payer has not paid or for payers who are known to be having financial difficulties that make the realization of amounts due unlikely. For receivables associated with patients, which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill, the Alliance records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between rates and the amounts actually collected after all reasonable collections efforts have been exhausted is charged against the allowance for uncollectible accounts.

The Alliance's allowance for doubtful accounts totaled \$49,449 and \$52,696 at June 30, 2013 and 2012, respectively. The allowance for doubtful accounts decreased from 26% of patient accounts receivable, net of contractual allowances, at June 30, 2012 to 23% of patient accounts receivable, net of contractual allowances, as of June 30, 2013. During 2013, MSHA began recording contractual allowances at time-of-billing for three additional payers, two of whom are MSHA's largest commercial payers. Previously, MSHA had recorded an allowance for bad debt for those three payers in addition to an estimated allowance for contractual adjustments. As a result of a more accurate methodology for recording contractual allowances for those three payers, MSHA was able to decrease its allowance for bad debts by a minimal amount. The provision for bad debts associated with the Alliance's ancillary service lines are not significant.

**NOTE I--THIRD-PARTY REIMBURSEMENT**

The Alliance renders services to patients under contractual arrangements with Medicare, Medicaid, TennCare, Blue Cross and various other commercial payers. The Medicare program pays for inpatient services on a prospective basis. Payments are based upon diagnosis related group assignments, which are determined by the patient's clinical diagnosis and medical procedures utilized. The Alliance also receives additional payments from Medicare based on the provision of services to a disproportionate share of Medicaid and other low income patients. Most Medicare outpatient services are reimbursed on a prospectively determined payment methodology. The Medicare program also reimburses certain other services on the basis of reasonable cost, subject to various prescribed limitations and reductions.

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE I--THIRD-PARTY REIMBURSEMENT - Continued**

Reimbursement under the State of Tennessee's Medicaid waiver program (TennCare) for inpatient and outpatient services is administered by various managed care organizations (MCOs) and is based on diagnosis related group assignments, a negotiated per diem or fee schedule basis. The Alliance also receives additional supplemental payments from the State of Tennessee. These supplemental payments recognized totaled \$8,455 and \$11,300 for the years ended June 30, 2013 and 2012, respectively. Such payments are not guaranteed in future periods.

The Virginia Medicaid program reimbursement for inpatient hospital services is based on a prospective payment system using both a per case and per diem methodology. Additional payments are made for the allowable costs of capital. Payments for outpatient services are based on Medicare cost reimbursement principles and settled through the filing of an annual Medicaid cost report.

Amounts earned under the contractual agreements with the Medicare and Medicaid programs are subject to review and final determination by fiscal intermediaries and other appropriate governmental authorities or their agents. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. During 2013, the State of Virginia outsourced its Medicaid program to six managed care organizations. ISHN provides the provider network for Southwest Virginia to five Virginia Medicaid managed care organizations; two of which are on an exclusive basis. ISHN is not at-risk under these contracts.

Activity with respect to audits and reviews of the governmental programs in the healthcare industry has increased and is expected to increase in the future. No additional specific reserves or allowances have been established with regard to these increased audits and reviews as management is not able to estimate such amounts, if any. Management believes that any adjustments from these increased audits and reviews will not have a material adverse impact on the consolidated financial statements. However, due to uncertainties in the estimation, it is at least reasonably possible that management's estimate will change in 2014, although the amount of any change cannot be estimated. The impact of final settlements of cost reports or changes in estimates increased net patient service revenue by \$1,328 in 2013 and decreased net patient service revenue by \$1,556 in 2012.

Participation in the Medicare program subjects the Alliance to significant rules and regulations; failure to adhere to such could result in fines, penalties or expulsion from the program. Management believes that adequate provision has been made for any adjustments, fines or penalties which may result from final settlements or violations of other rules or regulations. Management has represented that the Alliance is in substantial compliance with these rules and regulations as of June 30, 2013.

The Alliance has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, preferred provider organizations and employer groups. The basis

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE I—THIRD-PARTY REIMBURSEMENT - Continued**

for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

**NOTE J—EMPLOYEE BENEFIT PLANS**

The Alliance sponsors a retirement plan (the Plan) which covers substantially all employees. The Plan is a defined contribution plan which consists principally of employer-funded contributions. During 2013 and 2012, the Alliance made contributions to the Plan under a stratified system, whereby the Alliance's contribution percentage is based on each employee's years of service. Employees of certain other subsidiaries are covered by other plans, although such plans are not significant. The total expense related to defined contribution plans for the years ended June 30, 2013 and 2012 was \$16,121 and \$15,072, respectively.

NCH maintains a defined benefit pension plan and a post-retirement employee benefit plan. The accrued unfunded pension liability was \$3,028 and \$2,560, and the accrued unfunded post-retirement liability was \$4,943 and \$4,554 at June 30, 2013 and 2012, respectively.

The Alliance sponsors a secured executive benefit program (SEBP) for certain key executives. Contributions to the plan by the Alliance are based on an annual amount of funding necessary to produce a target benefit for the participants at their retirement date, although the Alliance does not guarantee any level of benefit will be achieved. The Alliance contributed \$1,020 and \$1,734 to the plan during 2013 and 2012, respectively. Other assets at June 30, 2013 and 2012 include \$10,721 and \$9,675, respectively, related to the Alliance's portion of the benefits which are recoverable upon the death of the participant. In addition, the Alliance sponsors a Section 457(f) plan for certain key executives. The Alliance contributed \$294 and \$452 to the Section 457(f) plan during 2013 and 2012, respectively.

**NOTE K—CONCENTRATION OF RISK**

The Alliance has locations primarily in upper East Tennessee and Southwest Virginia which is considered a geographic concentration. The Alliance grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payer agreements. Net patient service revenue from Washington County, Tennessee operations were approximately 51% and 51% of total net patient service revenue for 2013 and 2012, respectively.

The mix of receivables from patients and third-party payers based on charges at established rates is as follows as of June 30:

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE K—CONCENTRATION OF RISK - Continued**

	<b>2013</b>	<b>2012</b>
Medicare	38%	36%
TennCare/Medicaid	16%	14%
Commercial	28%	26%
Other third-party payers	9%	13%
Patients	9%	11%
	<b>100%</b>	<b>100%</b>

Approximately 88% and 94% of the consolidated total revenue, gains and support were related to the provision of healthcare services during 2013 and 2012, respectively. Admitting physicians are primarily practitioners in the regional area.

Two of the Alliance's Virginia hospitals' employees are covered under collective bargaining agreements which extend through February 2014 and January 2015, respectively.

The Hospital maintains bank accounts at various financial institutions covered by the Federal Deposit Insurance Corporation (FDIC). At times throughout the year, the Alliance may maintain bank account balances in excess of the FDIC insured limit. Management believes the credit risk associated with these deposits is not significant.

The Alliance routinely invests in investment vehicles as listed in Note C. The Alliance's investment portfolio is managed by outside investment management companies. Investments in corporate and foreign bonds, municipal obligations, money market funds, equities and other vehicles that are held by safekeeping agents are not insured or guaranteed by the U.S. government.

**NOTE L—INCOME TAXES**

BRMM and its subsidiaries file a consolidated federal tax return and separate state tax returns. As of June 30, 2013 and 2012, BRMM and its subsidiaries had net operating loss carryforwards for consolidated federal purposes of \$33,620 and \$35,968, respectively, related to operating loss carryforwards which expire through 2031. At June 30, 2013 and 2012, BRMM had state net operating loss carryforwards of \$70,347 and \$69,403, respectively, which expire through 2027. The net operating loss carryforwards may be offset against future taxable income to the extent permitted by the Internal Revenue Code and Tennessee Code Annotated.

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued  
(Dollars in Thousands)******Years Ended 2013 and 2012***

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**NOTE L--INCOME TAXES - Continued**

At June 30, 2013 and 2012, SWCH had federal and state net operating loss carryforwards of \$5,906 and \$5,614, respectively, which expire through 2032. The net operating loss carryforwards may be off-set against future taxable income to the extent permitted by the Internal Revenue Code and tax codes of the Commonwealth of Virginia.

Net deferred tax assets related to these carryforwards and other deferred tax assets have been substantially offset through valuation allowances equal to these amounts. Income taxes paid relate primarily to state taxes for certain subsidiaries and federal alternative minimum tax.

**NOTE M--RELATED PARTY TRANSACTIONS**

The Alliance enters into transactions with entities affiliated with certain members of the Board of Directors including transactions to construct Alliance facilities and provide professional services to the Alliance. Board members refrain from discussion and abstain from voting on transactions with entities with which they are related.

**NOTE N--OTHER COMMITMENTS AND CONTINGENCIES**

**Construction in Progress:** Construction in progress at June 30, 2013 represents costs incurred related to various hospital and medical office building facility renovations and additions and information technology infrastructure. The Alliance has outstanding contracts and other commitments related to the completion of these projects, and the cost to complete these projects is estimated to be approximately \$39,110 at June 30, 2013. The Alliance does not expect any significant costs to be incurred for infrastructure improvements to assets held for resale.

**Physician Contracts:** BRMM employs physicians to provide services to BRMM's physician practices through employment agreements which provide annual compensation, plus incentives based upon specified productivity levels. These contracts have various terms.

In addition, the Alliance has entered into contractual relationships with non-employed physicians to provide services in Upper East Tennessee and Southwest Virginia. These contracts guarantee certain base payments and allowable expenses and have terms of varying lengths. Amounts drawn and outstanding under each agreement are treated as a loan bearing interest at various rates and are subject to repayment over a specified period. The physician notes may also be amortized by virtue of the physician's continued practice in the specified community during the repayment period. A net receivable of \$884 and \$1,436 related to these agreements is included in the accompanying Consolidated Balance Sheets at June 30, 2013 and 2012, respectively.

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE N—OTHER COMMITMENTS AND CONTINGENCIES - Continued**

**Employee Scholarships:** The Alliance offers scholarships to certain individuals which require that the recipients return to the Alliance to work for a specified period of time after they complete their degree. Amounts due are then forgiven over a specific period of time as provided in the individual contracts. If the recipient does not return and work the required period of time, the funds disbursed on their behalf become due immediately and interest is charged until the funds are repaid. Other receivables at June 30, 2013 and 2012 include \$9,021 and \$8,005, respectively, related to students in school, graduates working at the Alliance and amounts due from others who are no longer in the scholarship program, net of an estimated allowance.

**Operating Leases and Maintenance Contracts:** Total lease expense for the years ended June 30, 2013 and 2012 was \$8,739 and \$8,823, respectively. Future minimum lease payments for each of the next five years and in the aggregate for the Alliance's noncancellable operating leases with remaining lease terms in excess of one year are as follows:

**Year Ending June 30,**

2014	\$	5,165
2015		6,044
2016		4,491
2017		2,459
2018		1,848
Thereafter		6,297
	\$	<u>26,304</u>

**Asset Retirement Obligation:** The Alliance has identified asbestos in certain facilities and is required by law to dispose of it in a special manner if the facility undergoes major renovations or is demolished; otherwise, the Alliance is not required to remove the asbestos from the facility. The Alliance has complied with regulations by treating the asbestos so that it presents no known immediate or future safety concerns. An asset retirement obligation has been established to the extent that sufficient information exists upon which to estimate the liability.

**Other:** The Alliance is a party to various transactions and agreements in the normal course of business, which include purchase and re-purchase agreements, put arrangements and other commitments, which may bind the Alliance to undertake additional transactions or activities in the future. In addition, the Alliance has agreed to guarantee a portion of the outstanding indebtedness of a joint venture. Management estimates that the fair value of the guarantee of this debt is immaterial as of June 30, 2013.

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)******Years Ended 2013 and 2012*****NOTE N—OTHER COMMITMENTS AND CONTINGENCIES - Continued**

***Healthcare Industry:*** Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed.

In March 2010, Congress adopted comprehensive health care insurance legislation, *Patient Care Protection and Affordable Care Act* and *Health Care and Education Reconciliation Act*. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens by 2019 through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

**NOTE O—RENTAL INCOME UNDER OPERATING LEASES**

The Alliance leases rental properties to third parties, most of whom are physician practices, for various terms, generally five years. The following is a schedule by year and in the aggregate of minimum future rental income due under noncancellable operating leases at June 30, 2013:

<u><i>Year Ending June 30,</i></u>	
2014	\$ 1,779
2015	1,487
2016	727
2017	379
2018	248
Thereafter	225
Total minimum future rentals	<u>\$ 4,845</u>

**NOTE P—FAIR VALUE OF FINANCIAL INSTRUMENTS**

The fair value of financial instruments has been estimated by the Alliance using available market information as of June 30, 2013 and 2012, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Alliance could realize in a current market exchange. The carrying value of substantially all financial instruments approximates fair value due to the nature or term of the instruments, except as described below.

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE P—FAIR VALUE OF FINANCIAL INSTRUMENTS - Continued**

**Investment in Joint Ventures:** It is not practical to estimate the fair market value of the investments in joint ventures.

**Other Long-Term Liabilities:** Estimates of reported and unreported professional liability claims, pension and post-retirement liabilities are discounted to approximate their estimated fair value. It is not practical to estimate the fair market value of other long-term liabilities due to uncertainty of when these amounts may be paid. Other long-term liabilities are not discounted.

**Long-Term Debt:** The fair value of long-term debt is estimated based upon quotes obtained from brokers for bonds and discounted future cash flows using current market rates for other debt. For long-term debt with variable interest rates, the carrying value approximates fair value.

The estimated fair value of the Alliance's financial instruments that have carrying values different from fair value is as follows at June 30:

	2013		2012	
	<i>Carrying Value</i>	<i>Estimated Fair Value</i>	<i>Carrying Value</i>	<i>Estimated Fair Value</i>
<b>FINANCIAL LIABILITIES:</b>				
Long-term debt	\$ 1,124,765	\$ 1,167,846	\$ 1,080,575	\$ 1,150,201

**NOTE Q—FAIR VALUE MEASUREMENT**

FASB ASC 820 establishes a three-level valuation hierarchy for disclosure of fair value measurements. The valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date. The three levels are defined as follows:

- Level 1 - Inputs based on quoted market prices for identical assets or liabilities in active markets at the measurement date.
- Level 2 - Observable inputs other than quoted prices included in Level 1, such as quoted prices for similar assets and liabilities in active markets; quoted prices for identical or similar assets and liabilities in markets that are not active; or other inputs that are observable or can be corroborated by observable market data. The Alliance's Level 2 investments are valued primarily using the market valuation approach.

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE Q—FAIR VALUE MEASUREMENT - Continued**

- Level 3 - Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Alliance's own assumptions.

In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Alliance's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment and considers factors specific to the asset or liability.

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis and long-term debt as disclosed at fair value as of June 30, 2013 and 2012:

	<i>Total</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
<b>June 30, 2013</b>				
Cash, cash equivalents and money market funds	\$ 66,075	\$ 66,075	\$ -	\$ -
U.S. Government securities	25,905	25,905	-	-
U.S. Agency securities	45,997	45,997	-	-
Corporate and foreign bonds	179,880	-	179,880	-
Municipal obligations	17,749	-	17,749	-
Preferred and asset backed securities	3,491	-	3,491	-
U.S. equity securities	10,944	10,944	-	-
Mutual funds	186,028	125,479	60,548	-
Other	37,353	-	-	37,353
<b>Total assets</b>	<b>\$ 573,422</b>	<b>\$ 274,400</b>	<b>\$ 261,668</b>	<b>\$ 37,353</b>
Fair value of derivative agreements - Note D	\$ (8,185)	\$ -	\$ -	\$ (8,185)
Fair value of long-term debt	\$ (1,167,846)	\$ -	\$ -	\$ (1,167,846)

## MOUNTAIN STATES HEALTH ALLIANCE

*Notes to Consolidated Financial Statements - Continued*  
*(Dollars in Thousands)*

*Years Ended 2013 and 2012*

## NOTE Q—FAIR VALUE MEASUREMENT - Continued

	<i>Total</i>	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>
<b>June 30, 2012</b>				
Cash, cash equivalents and money market funds	\$ 85,017	\$ 85,017	\$ -	\$ -
U.S. Government securities	15,693	15,693	-	-
U.S. Agency securities	62,437	62,437	-	-
Corporate and foreign bonds	52,581	-	52,581	-
Municipal obligations	961	-	961	-
Preferred and asset backed securities	11,183	-	11,183	-
U.S. equity securities	28,344	28,344	-	-
Mutual funds	141,968	97,600	44,368	-
Other	34,880	-	-	34,880
<b>Total assets</b>	<b>\$ 433,064</b>	<b>\$ 289,091</b>	<b>\$ 109,093</b>	<b>\$ 34,880</b>
Fair value of derivative agreements - Note D	\$ (19,381)	\$ -	\$ -	\$ (19,381)
Fair value of long-term debt	\$ (1,150,201)	\$ -	\$ -	\$ (1,150,201)

The valuation of the Alliance's derivative agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses certain observable market-based inputs. The fair values of interest rate agreements are determined by netting the discounted future fixed cash payments (or receipts) and the discounted expected variable cash receipts (or payments). The variable cash receipts (or payments) are based on the expectation of future interest rates and the underlying notional amount. The Alliance also incorporates credit valuation adjustments (CVAs) to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. The CVA on the Alliance's interest rate swap agreements at June 30, 2013 and 2012 resulted in a decrease in the fair value of the related liability of \$3,080 and \$5,726, respectively.

A certain portion of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Alliance's credit risk used in the CVAs, are unobservable inputs available to a market participant. As a result, the Alliance has determined that the interest rate swap valuations are classified in Level 3 of the fair value hierarchy.

The following tables provide a summary of changes in the fair value of the Alliance's Level 3 financial assets and liabilities during the fiscal years ended June 30, 2013 and 2012:

**MOUNTAIN STATES HEALTH ALLIANCE****Notes to Consolidated Financial Statements - Continued**  
**(Dollars in Thousands)****Years Ended 2013 and 2012****NOTE Q--FAIR VALUE MEASUREMENT - Continued**

	<i>Trading Securities</i>	<i>Derivatives, Net</i>
<b>July 1, 2011</b>	<b>\$ 32,718</b>	<b>\$ (110,732)</b>
Total unrealized/realized gains in the Performance Indicator, net	1,466	(6,198)
Net investment income	1,221	515
Purchases	5,107	-
Settlements	-	97,034
Distributions	(5,632)	-
<b>June 30, 2012</b>	<b>34,880</b>	<b>(19,381)</b>
Total unrealized/realized gains in the Performance Indicator, net	1,614	457
Net investment income	1,360	399
Purchases	807	-
Settlements	-	10,340
Distributions	(1,308)	-
<b>June 30, 2013</b>	<b>\$ 37,353</b>	<b>\$ (8,185)</b>

There were no changes in valuation techniques in 2013 or 2012.

**NOTE R--OPERATING EXPENSES BY FUNCTIONAL CLASSIFICATION**

The Alliance does not present expense information by functional classification because its resources and activities are primarily related to providing healthcare services. Further, since the Alliance receives substantially all of its resources from providing healthcare services in a manner similar to business enterprises, other indicators contained in these consolidated financial statements are considered important in evaluating how well management has discharged their stewardship responsibilities.

**NOTE S--SUBSEQUENT EVENTS**

In November 2013, Unicoi County Memorial Hospital (UCMH), a 48 bed acute care hospital located in Erwin, Tennessee, became a member of the Alliance. UCMH has approximately 250 employees and offers emergency, surgical, and home health services. Nursing home services are provided in a 46 licensed bed long term care facility. The Alliance will fund the acquisition from cash flow and intends to construct a new acute care hospital in Erwin, Tennessee. After consideration of the revenues and expenses expected from operation of the facility, management of the Alliance does not expect this acquisition to have a material effect on the Alliance.

**MOUNTAIN STATES HEALTH ALLIANCE**

***Notes to Consolidated Financial Statements - Continued***  
***(Dollars in Thousands)***

***Years Ended 2013 and 2012***

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**NOTE S—SUBSEQUENT EVENTS - Continued**

In July 2013, the Alliance issued \$16,235 (Series 2013A) tax-exempt variable rate Hospital Revenue Bonds and \$99,680 (Series 2013B) variable rate Taxable Hospital Refunding Revenue Bonds through The Health and Educational Facilities Board of the City of Johnson City, Tennessee. The proceeds from the Series 2013A Bonds will be used to finance or refinance capital improvements and equipment acquisitions and pay issuance costs related to these Bonds. The proceeds from the Series 2013B Bonds will be used to refund \$97,915 of the Series 2007B-2 Bonds and to pay issuance costs associated with these Bonds. Contemporaneously with the issuance of the Series 2013A and Series 2013B Bonds, the Alliance refunded the Series 2008A, Series 2008B, Series 2011C, Series 2011D, Series 2012B and Series 2012C through private placements with financial institutions.

At June 30, 2013 and 2012, the Alliance owned membership units in Premier, Inc. Subsequent to yearend Premier, as part of a reorganization, converted to a publically traded entity. As part of its reorganization, certain of the Alliance's membership units were redeemed for approximately \$3,000 and a gain was recognized on the sale of these units. Unredeemed units continue to be held by the Alliance and may be effectively exchanged for Class A common stock of Premier ratably over a seven year period. The unredeemed membership units may be exchanged for up to 723 thousand Class A shares.

## Other Information

## MOUNTAIN STATES HEALTH ALLIANCE

## Schedule of Expenditures of Federal and State Awards

Year Ended June 30, 2013

CFDA Number	Award Number (Award Allocation)	Program Name (Program Period)	Grantee	Pass-Through Grantee Agency	Receivable (Payable) Balance at July 1, 2012	Receipts	Amounts Received by Expenditures	Amounts Returned or Refunded to Grantee	Receivable (Payable) Balance at June 30, 2013
FEDERAL AND STATE AWARDS:					\$ -	\$ 46,600	\$ 46,600	\$ -	\$ -
10.776	48-046-020476282 (100% Federal)	Rural Housing Service Grant (None)	U.S. Department of Agriculture	N/A					
Total U.S. Department of Agriculture					-	46,600	46,600	-	-
93.211	SH2AIT16637-03-00 (100% Federal)	Telehealth Grant Network Program (9/1/09 - 8/31/12)	U.S. Department of Health and Human Services	N/A	41,185	159,614	118,429	-	-
93.301	10-557-JCX (100% Federal)	Small Rural Hospital Improvement Program (9/1/09 - 8/31/10)	U.S. Department of Health and Human Services	Virginia Department of Health	(13,515)	-	-	-	(13,515)
93.301	11-557-JCX (100% Federal)	Small Rural Hospital Improvement Program (9/1/10 - 8/31/11)	U.S. Department of Health and Human Services	Virginia Department of Health	(14,884)	-	-	-	(14,884)
93.301	GR-12-35362-00 (100% Federal)	Small Rural Hospital Improvement Program (7/1/11 - 8/31/11)	U.S. Department of Health and Human Services	Tennessee Department of Health	(2,791)	-	-	-	(2,791)
93.301	12-557-04 (100% Federal)	Small Rural Hospital Improvement Program (9/1/11 - 8/31/12)	U.S. Department of Health and Human Services	Virginia Department of Health	(750)	-	750	-	-
93.301	12-557-18 (100% Federal)	Small Rural Hospital Improvement Program (7/1/11 - 6/30/12)	U.S. Department of Health and Human Services	Virginia Department of Health	-	7,504	-	-	(7,504)
93.301	13-557-JCX (100% Federal)	Small Rural Hospital Improvement Program (9/1/12 - 8/31/13)	U.S. Department of Health and Human Services	Virginia Department of Health	-	14,228	8,353	-	(5,875)
93.301	None (100% Federal)	Small Rural Hospital Improvement Program (9/1/11 - 8/31/12)	U.S. Department of Health and Human Services	Tennessee Department of Health	-	8,500	8,500	-	-

See notes to schedule of expenditures of federal and state awards.

## MOUNTAIN STATES HEALTH ALLIANCE

## Schedule of Expenditures of Federal and State Awards - Continued

Year Ended June 30, 2013

CFDA Number	Award Number (Award Allocation)	Program Name (Program Period)	Grantor	Pass-Through Grantor Agency	Receivable (Payable) Balance at July 1, 2012	Receipts	Amounts Earned by Expenditures	Amounts Released or Returned to Grantor	Receivable (Payable) Balance at June 30, 2013
93.778	GR-11-31755-00 (50% Federal) (50% State)	High Risk Perinatal Program* (7/1/10 - 6/30/13)	U.S. Department of Health and Human Services	Tennessee Department of Finance and Administration	205,766	493,995	381,500	-	93,271
93.889	GR-1236-XCKK (100% Federal)	Hospital Preparedness Program (7/1/11 - 9/30/12)	U.S. Department of Health and Human Services	Tennessee Department of Health	(151)	-	151	-	-
93.889	GR-13-XXXXXX (100% Federal)	Hospital Preparedness Program (7/1/12 - 6/30/13)	U.S. Department of Health and Human Services	Tennessee Department of Health	-	200,000	123,449	-	(76,551)
93.889	None (100% Federal)	ASPR Conference Funding (7/1/12 - 6/30/13)	U.S. Department of Health and Human Services	Virginia Department of Health	-	3,149	3,114	-	(35)
93.889	None (100% Federal)	National Women's Health Week (2/4/11 - 6/29/12)	U.S. Department of Health and Human Services	John Snow, Inc.	(1,133)	-	1,020	-	(113)
93.889	None (100% Federal)	Healthcare Emergency Management (7/1/12 - 6/30/13)	U.S. Department of Health and Human Services	Virginia Department of Health	-	-	2,538	-	2,538
			Total U.S. Department of Health and Human Services		213,727	886,990	647,804	-	(25,459)
N/A	None (100% State)	Get With Guidelines Stroke Program (None)	Virginia Department of Health	N/A	-	1,854	5,634	-	3,780
N/A	Various (100% State)	Inpatient Psychiatric Treatment of Uninsured Committed Patients (7/1/11 - 6/30/14)	Department of Mental Health and Developmental Disabilities	N/A	331,280	2,417,931	2,509,335	-	422,684

See notes to schedule of expenditures of federal and state awards.

## MOUNTAIN STATES HEALTH ALLIANCE

*Schedule of Expenditures of Federal and State Awards - Continued**Year Ended June 30, 2013*

<i>CFDA Number</i>	<i>Award Number (Award Allocation)</i>	<i>Program Name (Program Period)</i>	<i>Grantor</i>	<i>Pass-Through Grantee Agency</i>	<i>Receivable (Payable) Balance at July 1, 2012</i>	<i>Receipts</i>	<i>Amounts Received by Expenditures</i>	<i>Amounts Released or Returned to Grantee</i>	<i>Receivable (Payable) Balance at June 30, 2013</i>
N/A	None (100% State)	Medicare Rural Hospital Flexibility Grant (None)	Tennessee Department of Health	Tennessee Hospital Association		4,000	-	-	(4,000)
N/A	GR-13-34103-00 (100% State)	Project Diabetes Initiative Services (8/15/12 - 6/30/13)	Tennessee Department of Health	N/A		2,169	2,229	-	60
N/A	None (100% State)	Essential Services Dispensary of Hope (7/1/11 - 2/28/14)	Tennessee Housing Development Agency	City of Johnson City	1,875	2,500	1,250	-	625
<b>TOTAL FEDERAL AND STATE AWARDS</b>					<b>\$ 546,882</b>	<b>\$ 3,362,044</b>	<b>\$ 3,212,832</b>	<b>\$ -</b>	<b>\$ 397,690</b>

\*Denotes major program.

*See notes to schedule of expenditures of federal and state awards.*

**MOUNTAIN STATES HEALTH ALLIANCE*****Notes to Schedule of Expenditures of Federal and State Awards******Year Ended June 30, 2013*****NOTE A--BASIS OF PRESENTATION**

The accompanying schedule of expenditures of federal and state awards includes the federal and state award activity of the Alliance and is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations* and the State of Tennessee Comptroller of the Treasury. Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the basic consolidated financial statements.

**NOTE B--FEDERAL AWARDS EXPENDED**

The accompanying schedule of expenditures of federal and state awards includes federal and state award activity organized by federal program. State pass-through funding is included as part of the total program activity, with state allocation percentages disclosed. Total federal awards expended were as follows for the year ending June 30, 2013:

Telehealth Grant Network Program	\$ 118,429
Small Rural Hospital Improvement Program	17,603
High Risk Perinatal Program	190,750
Hospital Preparedness Program	129,252
Rural Housing Service Grant	46,600
National Women's Health Week	1,020
Total federal awards expended	<u>\$ 503,654</u>

**NOTE C--CONTINGENCIES**

The Alliance's federal programs are subject to financial and compliance audits by grantor agencies which, if instances of material noncompliance are found, may result in disallowed expenditures and affect the Alliance's continued participation in specific programs. The amount, if any, of expenditures which may be disallowed by the grantor agencies cannot be determined at this time, although the Alliance expects such amounts, if any, to be immaterial.

**MOUNTAIN STATES HEALTH ALLIANCE*****Schedule of Prior Audit Findings******Year Ended June 30, 2013***

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There were no prior audit findings.



PERSHING YOAKLEY & ASSOCIATES, P.C.  
 One Cherokee Mills, 2220 Sutherland Avenue  
 Knoxville, TN 37919  
 p: (865) 673-0844 | f: (865) 673-0173  
 www.pyapc.com

**INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER  
 FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS  
 BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN  
 ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS**

To the Board of Directors of  
 Mountain States Health Alliance:

We have audited, in accordance with auditing standards generally accepted in the United States of America and the Standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Mountain States Health Alliance and its subsidiaries (the Alliance) which comprise the consolidated balance sheets as of June 30, 2013 and 2012, and the related statements of operations, changes in net assets and cash flows for the years ended June 30, 2013 and 2012, and the related notes to the consolidated financial statements, and have issued our report thereon dated December 16, 2013.

**Internal Control Over Financial Reporting**

In planning and performing our audits of the consolidated financial statements, we considered the Alliance's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control. Accordingly, we do not express an opinion on the effectiveness of the Alliance's internal control.

*A deficiency in internal control* exists when the design or operation of a control does not allow management or employees in the normal course of performing their assigned functions, to prevent or detect and correct misstatements on a timely basis. *A material weakness* is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the Alliance's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. *A significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention to those charged with governance.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

**Compliance and Other Matters**

As part of obtaining reasonable assurance about whether the Alliance's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of the Alliance's consolidated financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

We noted certain matters that we have reported to management of the Alliance in a separate letter dated December 16, 2013.

**Purpose of this Report**

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Alliance's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Alliance's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

*Rebecca Yorkley: Assistant PC*

Knoxville, Tennessee  
December 16, 2013



PERSHING YOAKLEY & ASSOCIATES, P.C.  
 One Cherokee Mills, 2220 Sutherland Avenue  
 Knoxville, TN 37919  
 p: (865) 673-0844 | f: (865) 673-0173  
 www.pyapc.com

**INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH  
 REQUIREMENTS THAT COULD HAVE A DIRECT AND MATERIAL  
 EFFECT ON EACH MAJOR PROGRAM AND ON INTERNAL CONTROL OVER  
 COMPLIANCE REQUIRED BY OMB CIRCULAR A-133**

To the Board of Directors of  
 Mountain States Health Alliance:

**Report on Compliance for Each Major Federal Program**

We have audited Mountain States Health Alliance and its subsidiaries' (the Alliance) compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) Circular A-133 *Compliance Supplement* that could have a direct and material effect on the Alliance's major federal program for the year ended June 30, 2013. The Alliance's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

**Management's Responsibility**

Management is responsible for compliance with the requirements of laws, regulations, contracts, and grants applicable to its major federal program.

**Auditor's Responsibility**

Our responsibility is to express an opinion on compliance for the Alliance's major federal program. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and OMB Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*. Those standards and OMB Circular A-133 require that we plan and perform the compliance audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the Alliance's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of the Alliance's compliance.

### **Opinion on the Major Federal Program**

In our opinion, Mountain States Health Alliance and its subsidiaries complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended June 30, 2013.

### **Report on Internal Control Over Compliance**

The management of the Alliance is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the Alliance's internal control over compliance with types of requirements that could have a direct and material effect on the major federal program to determine auditing procedures that are appropriate in the circumstances for the purpose of expressing our opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with OMB Circular A-133, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the Alliance's internal control over compliance.

*A deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. *A material weakness in internal control over compliance* is a deficiency or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A significant deficiency in internal control over compliance is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be deficiencies, significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on requirements of OMB Circular A-133. Accordingly, this report is not suitable for any other purpose.

*Patricia Jenkins, Accountant PC*

Knoxville, Tennessee  
December 16, 2013

**MOUNTAIN STATES HEALTH ALLIANCE*****Schedule of Findings and Questioned Costs******Year Ended June 30, 2013*****Section I - Summary of Auditor's Results*****Financial Statements***

1. The auditor's report expresses an unmodified opinion on the consolidated financial statements of Mountain States Health Alliance.
2. No significant deficiencies relating to the audit of the consolidated financial statements are reported in the *Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards*. In addition, we noted no findings that are required to be reported under *Government Auditing Standards*.
3. No instances of noncompliance material to the consolidated financial statements of Mountain States Health Alliance which would be required to be reported in accordance with *Government Auditing Standards* were disclosed during the audit.

***Federal Awards***

4. No significant deficiencies, findings or questioned costs relating to the audit of the major federal award program are reported in the *Independent Auditor's Report on Compliance with Requirements That Could Have a Direct and Material Effect on Each Major Program and on Internal Control Over Compliance Required By OMB Circular A-133* or in this schedule.
5. The auditor's report on compliance for the major federal award program for Mountain States Health Alliance expresses an unmodified opinion on its major federal program.
6. No audit findings relative to the major federal award program for Mountain States Health Alliance are reported in this schedule in accordance with Section 510(a) of OMB Circular A-133.
7. The program tested as a major program is as follows:

<u>Name</u>	<u>CFDA Number</u>
High Risk Perinatal Program	93.778

8. The threshold for distinguishing Types A and B programs was \$300,000.
9. Mountain States Health Alliance qualified as a low-risk auditee.

**MOUNTAIN STATES HEALTH ALLIANCE*****Schedule of Findings and Questioned Costs - Continued******Year Ended June 30, 2013***

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**Section II – Financial Statement Findings**

This section identifies the significant deficiencies, material weaknesses, fraud, illegal acts, violations of provisions of contracts and grant agreements, and abuse related to the consolidated financial statements for which *Government Auditing Standards* require reporting in a Circular A-133 audit.

Not applicable, no financial statement findings.

**Section III – Federal Awards Findings**

This section identifies the audit findings required to be reported by Section 510(a) of Circular A-133 (for example, significant deficiencies, material weaknesses, and material instances of noncompliance, and any related questioned costs), as well as any abuse findings involving federal awards that is material to a major program.

Not applicable, no federal awards findings or questioned costs.

**ATTACHMENT C,  
CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE, 7(D)  
Summary Statement of Deficiencies and (Approved) Provider's Plan of  
Correction**



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
OFFICE OF HEALTH LICENSURE AND REGULATION  
EAST TENNESSEE REGION  
7175 Strawberry Plains Pike, Ste 103  
Knoxville TN 37914  
Phone: 865-594-9396 Fax: 865-594-2168

August 11, 2014

Mr. David Nicely, Administrator  
Johnson City Medical Center  
400 N State of Franklin Road  
Johnson City TN 37604

Provider Number: 44-0063

Dear Mr. Nicely:

Enclosed is the Statement of Deficiencies developed as the result of the complaint investigation conducted at the Johnson City Medical Center on **July 28-August 4, 2014**. You are requested to submit a Plan of Correction by **August 21, 2014** with acceptable time frames for correction of the cited deficiencies. Corrective action must be achieved prior to **September 18, 2014**. Please notify this office when these deficiencies are corrected.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

Please submit the Plan of Correction (POC), by **August 21, 2014**:

State of Tennessee Department of Health  
Health Care Facilities  
7175 Strawberry Plains Pike, Ste 103  
Knoxville TN 37914

Your POC must contain the following:

- What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice.
- How you will identify other residents/patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

Mr. David Nicely  
August 11, 2014  
Page 2

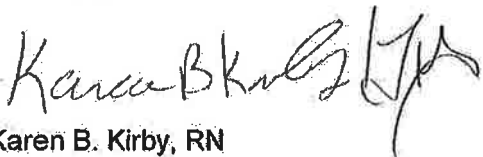
- How the corrective action(s) will be monitored and the person(s) responsible for monitoring to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

**Please put your Plan of Correction on the Statement of Deficiencies form in the "Provider's Plan of Correction" column. In the "Completion Date" column of the form, list the date corrective actions have been or will be completed. Please make sure the administrator's signature and date are on the bottom line of the Statement of Deficiencies/Plan of Correction State Form.**

**Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.**

If you have any questions, please contact this office at (865) 594-9396 or by facsimile at (865) 594-2168.

Sincerely,



Karen B. Kirby, RN  
Regional Administrator  
East TN Health Care Facilities

KK: kg

Enclosure: CMS-2567

TN00033301, TN0003328, TN00033661, TN00033661 and TN00033804



August 21, 2014

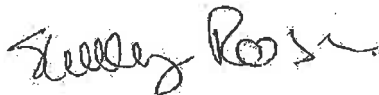
Karen Kirby  
State of Tennessee Department of Health  
Health Care Facilities  
7175 Strawberry Plains Pike, Ste 103  
Knoxville, TN 37914

Dear Ms. Kirby,

Enclosed is the Plan of Correction for Johnson City Medical Center addressing the findings from the complaint investigation conducted on July 28 - August 4, 2014. We have faxed the attached document to 865-594-2168 on August 21, 2014 to comply with the due date noted in your July 11, 2014 letter.

If you have any questions, please contact me at 423-431-6936.

Sincerely,



Shelley Rose  
Risk Manager  
Johnson City Medical Center

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/11/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  440063		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/04/2014	
NAME OF PROVIDER OR SUPPLIER  JOHNSON CITY MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 400 N STATE OF FRANKLIN RD JOHNSON CITY, TN 37604			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 000	INITIAL COMMENTS			A 000	Action Plan for A 749		
	During complaint investigation #33661, #33328, #33804, #33301, and #33753 conducted on July 28, 2014, through July 30, 2014, at Johnson City Medical Center, no deficiencies were cited in relation to complaints #33328, #33301, and #33753.				The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.		
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM			A 749			
	The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.				The STANDARD is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview the facility failed to follow infection control precautions during urinary catheter care for one patient of five patients reviewed.		
	This STANDARD is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to follow infection control precautions during urinary catheter care for one patient (#1) of five patients reviewed.				Plan of Correction		
	The findings included:				Action Item 1		
	Patient #1 was admitted to the facility on July 26, 2014, after a motor vehicle accident with a diagnosis of a Subarachnoid Hemorrhage.				The deviation from standard infection control practices was immediately identified and addressed and the deficient care to the patient remedied. The registered nurse caring for the patient recognized his error and it was discussed with his manager immediately following the incident.		07/30 2014
	Medical record review revealed a urinary catheter was inserted on July 26, 2014, and the patient was admitted to the Intensive Care Unit.						
	Observation on July 28, 2014, at 5:00 p.m., in the patient's room in the Intensive Care Unit, revealed Registered Nurse (RN) #1 performing urinary catheter care for the patient. Further observation revealed the RN donned gloves and						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Tony Benton* VP/Interim CEO, Washington County 8/20/2014

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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A 749	<p>Continued From page 1</p> <p>wiped the patient's perineal area from back to front during the care with a clean wash cloth. Continued observation revealed the RN used the same soiled wash cloth and wiped the patient's perineal area again from back to front. Further observation revealed the RN opened a drawer and retrieved a prepackaged CHG wipe (used for the prevention of Urinary Tract Infections) without changing the soiled gloves, opened the prepackaged CHG wipe, and cleaned the urinary catheter without changing the gloves or sanitizing the hands.</p> <p>Review of facility policy Urinary Catheter: Indwelling Catheter Care, not dated, revealed, "...for females gently retract the labia to fully expose urethral meatus and catheter insertion site...maintain position of hand throughout the procedure...bacterial growth is common where the urinary catheter enters the urethral meatus in both men and women...perform catheter care each shift as post of routine perineal care..."</p> <p>Interview with RN #1 on July 28, 2014, at 5:15 p.m., in patient #1's room, confirmed the nurse cleaned the patient's perineal area from back to front two times with the wash cloth. Further interview confirmed the nurse obtained the CHG wipes from the clean drawer using the soiled gloves and cleaned the patient's urinary catheter with the soiled gloves.</p> <p>Interview with the Infection Control Preventist on July 29, 2014, at 8:30 a.m., in the conference room, confirmed the nurse failed to follow standard infection control practices during the urinary catheter care.</p> <p>C/O #33804</p>	A 749	<p><b>Action plan for A 749 (cont.)</b></p> <p><b>Action Item 2</b> The individual registered nurse involved in the deviation from standard practice received individual education/mentoring from his manager related to the areas of concern and has an action plan in place to ensure the deficient practice does not recur.</p> <p><b>Action Item 3</b> Computer Based Learning (CBL): The CAUTI (Catheter Associated Urinary Tract Infection) prevention module assigned to all nursing team members annually was reviewed and all content updated with focus on evidence based criteria for necessity, appropriate insertion technique, assessment/maintenance, removal criteria and infection prevention.</p> <p><b>Action Item 4</b> The CBL will be assigned to all nursing staff on nursing unit 2900 with 100% successful completion to be achieved no later than September 17, 2014. Successful</p>	<p>08/15/2014</p> <p>09/17/2014</p> <p>09/17/2014</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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137

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A 821	<p>482.43(c)(4) REASSESSMENT OF A DISCHARGE PLAN</p> <p>The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to have an accurate discharge plan which included Discharge Medication Reconciliation for one patient (#7) of eleven patients reviewed.</p> <p>The findings included:</p> <p>Patient #7 was admitted to the facility on February 5, 2014, for a total knee replacement and the patient was discharged to a Skilled Nursing Facility on February 10, 2014.</p> <p>Medical record review of an admission history and physical dated February 5, 2014, at 3:33 p.m., revealed "...patient long history of right knee osteoarthritis...has failed conservative treatment and elected for right knee replacement...medical history...heart with an atrial septal defect, atrial fibrillation, leaky valve and hypertension...the patient has elected for right total knee replacement...will continued following the patient throughout the hospital course...the patient has been medically cleared by her primary care physician..."</p> <p>Medical record review of a consultation report dated February 5, 2014, at 1:00 p.m., written by the Hospitalist, revealed, "...presents for total knee replacement and consulted for medical</p>	A 821	<p><b>Action plan for A 749 (cont.)</b></p> <p>completion is measured by a passing score of 80% or greater. Individuals who fail to successfully complete the CBL initially will received remediation and re-take the learning/test until successfully completed.</p> <p><b>Action Item 5</b> FACT Sheet for Indwelling Urinary Catheter Care Created and posted on nursing unit 2900 in team member areas to reinforce expectations of standard practice</p> <p><b>Action Item 6</b> Urinary Catheter Simulation Lab/Skills Fair Focus on proper insertion technique, care and maintenance of indwelling urinary catheters 100% of all nursing staff on nursing unit 2900 to attend and be evaluated via return demonstration no later than September 17, 2014.</p>	<p>08/12/2014</p> <p>09/17/2014</p>	

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138

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A 821	<p>Continued From page 3</p> <p>management...medications: Pardaxa (blood thinner) 150mg (milligrams) twice a day, Digoxin (medication used to slow the heart rate down) 250mcg (micrograms) daily, Diltiazem (medication used to control the blood pressure and heart rate) 120mg daily, Lasix (diuretic) 40mg twice a day, Potassium Chloride (medication used for potassium replacement) 20 mEq (milliequivalents) daily, Salsalate (anti-inflammatory medication) 750mg three times a day, Sotalol (medication used to control cardiac arrhythmias) 120mg daily, and Trazodone (medication used for depression) 100mg at bedtime...plan...for hypertension we will continue with the beta blocker with holding parameters...that will begin tomorrow on the 6th, and we will resume her Lasix on the 6th or 7th depending on how she is doing...this plan of care was outlined with the patient and the patient's husband...they are agreeable..."</p> <p>Medical record review of the Admission Medication Reconciliation Report dated February 5, 2014, at 1:57 p.m., revealed "...Lasix 40mg twice a day...not continued..."</p> <p>Medical record review of a Physicians Progress note dated February 7, 2014, at 11:20 a.m., written by the Hospitalist, revealed, "...on Lasix at home...on hold at this time..."</p> <p>Medical record review of a Physicians Progress note dated February 9, 2014, at 8:15 a.m., written by the cardiologist, revealed "...Lasix 40mg BID (twice a day)...restart 1x day..."</p> <p>Medical record review of an electronic Physicians Order sheet dated February 9, 2014, at 8:31 a.m., written by the patient's Primary Care Physician,</p>	A 821	<p>Action plan for A 749 (cont.)</p> <p><b>Action Item 7</b> <b>Auditing for Compliance</b> The nurse manager and/or infection prevention will observe the catheter care performed on at least 3 patients weekly beginning in September 2014 to ensure compliance with standard infection control practices. The audits will continue until 100% compliance has been met for 6 consecutive months. Findings that do not meet the target of 100% will have a review of the event and action plan, including education, to correct the deficiency. The findings of the audit will be part of the Quality Assurance/Process Improvement reporting process for Johnson City Medical Center.</p> <p><b>Action Plan for A821</b></p> <p>The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.</p>	09/15/2014	

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139

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A 821	<p>Continued From page 4 revealed "...Lasix 40mg x 1 daily..."</p> <p>Medical record review of the Discharge Medication Administration Record dated February 9, 2014, at 8:31 a.m., revealed "...Lasix 40mg one tablet one time a day..."</p> <p>Medical record review of the Nursing Assessment Reports revealed the patient's weights were as follows: February 5, 2014, 75kg (kilograms) [165 pounds]; February 9, 2014, 92 kg [202 pounds].</p> <p>Medical record review of the Doctors Order Sheet Medication Transfer Form revealed the transfer form was printed off by the 600 Nursing Unit on February 7, 2014, at 4:39 p.m. Further medical record review revealed the telephone order from the discharging physician received by Registered Nurse (RN) #10 on February 10, 2014, at 11:49 a.m., revealed no physician's order for Lasix.</p> <p>Interview with RN #10 on July 29, 2014, at 3:00 p.m., in the conference room, revealed the nurse was working the day the patient was discharged from the facility to the Skilled Nursing Facility (February 10, 2014). Further interview revealed the nurse spoke with the patient's discharging physician and confirmed the medications on the Discharge Medication Reconciliation Sheet which was dated February 7, 2014. Further interview revealed "...the medications on the form were given to the physician by telephone and I wrote the telephone order to continue the medications...Lasix was not on the reconciliation sheet that I spoke with the physician about..." Further interview revealed "...the patient was receiving Lasix on February 10, 2014..."</p> <p>Interview with the CNO on July 29, 2014, at 2:15</p>	A 821	<p><b>Action Plan for A821 (cont.)</b></p> <p>The STANDARD is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to have an accurate discharge plan which included Discharge Medication Reconciliation for one patient of the eleven patients interviewed.</p> <p><b>Plan of Correction</b></p> <p><b>Action Item 1</b> The inaccuracy of the discharge medications for the identified patient was not discovered until after the patient was transferred to another facility. The patient did not require readmission and the error was addressed at the other facility.</p> <p><b>Action Item 2</b> A complete review of the error and medical record was conducted by nursing administration and risk management.</p>	<p>N/A</p> <p>08/13/ 2014</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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140

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A 821	<p>Continued From page 5</p> <p>p.m., in the conference room, revealed "...the Lasix and Potassium was held on admission due to the patient's blood pressure being low...the patient was started back on the Lasix on February 9, 2014, and given as ordered by the physician..."</p> <p>Interview with the Nurse Manager for the 600 Wing Unit on July 29, 2014, at 2:30 p.m., in the conference room, revealed "...the reconciliation form for the patient was printed off on February 7, 2014, when the patient was anticipated to be discharged from the facility...the patient had some issues with a fast heart rate and...discharge was postponed until the patient was medically stable..." Continued interview revealed "...the Discharge Medication Reconciliation Sheet should have been reprinted on February 10, 2014, but it was not, so the discharge medication reconciliation form only showed the medications from February 7, 2014...therefore the Lasix was not written on the discharge medication form..." Further interview confirmed the Lasix was not continued on the Discharge Medication Reconciliation Sheet as ordered by the physician and the facility failed to perform an accurate discharge plan for the patient.</p> <p>C/O #33661</p>			A 821	<p><b>Action Plan for A821 (cont.)</b></p> <p><b>Action Item 3</b> The individual registered nurse involved in the completion of the inaccurate discharge medication reconciliation received individual education/mentoring from her manager related to the areas of concern and has an action plan in place to ensure the deficient practice does not recur.</p> <p><b>Action Item 4</b> All nursing staff and case managers on nursing units 6400 and 6500 will receive education specific to medication reconciliation with specific focus on discharge. 100% completion will be achieved no later than September 17, 2014.</p> <p><b>Action Item 5</b> It was identified that the font for the "printed on" date on the discharge medication form was very small and could contribute to the failure to identify an outdated form. The font size was addressed by the IS department and completed on September 18, 2014.</p>		<p>8/15/2014</p> <p>09/17/2014</p> <p>09/18/2014</p>

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TNP531121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 08/04/2014
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

JOHNSON CITY MEDICAL CENTER

400 N STATE OF FRANKLIN RD  
JOHNSON CITY, TN 37604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
H 002	1200-8-1 No Deficiencies  During complaint investigation #33361, # 33328, #33804, #33301, and #33753 conducted on July 28, 2014, through July 30, 2014, at Johnson City Medical Center, no deficiencies were cited under 1200-8-1, Standards for Hospitals.	H 002	<b>Action Plan for A821 (cont.)</b>  <b>Auditing for Compliance</b> The nurse manager and/or designee will audit transferring medication records at least 5 patient weekly beginning in September 2014 to ensure compliance with the discharge medication reconciliation process. The audits will continue until 100% compliance has been met for 6 consecutive months. Findings that do not meet the target of 100% will have a review of the event and action plan, including education, to correct the deficiency. The findings of the audit will be part of the Quality Assurance/Process Improvement reporting process for Johnson City Medical Center.	07/15/2015

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

TEL611

continuation sheet 1 of 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445356	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  04/30/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 000	INITIAL COMMENTS  The Statement of Deficiencies was amended on May 15, 2014, F-371.	F 000			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F 272  Resident #80 was immediately assessed by DON/designee for dental needs and no negative effects noted. Care plan was immediately updated to reflect patient care needs.  All other residents were assessed by DON/designee for dental needs and no further deficient practices were noted.  DON/Designee to inservice all registered nurses on patient assessment and care plan documentation by 5/20/14.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

*[Signature]* 3384 *Administrator* 5/16/14  
This statement, ending with the word "deficiency," denotes a deficiency which the institution may be excused from correcting providing it is determined that the findings provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445356	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/30/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to assess dental needs for one resident (#80) of twenty-one residents reviewed during stage 2.</p> <p>The findings included:</p> <p>Resident #80 was admitted to the facility on April 17, 2014, with diagnoses including Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Diabetes Mellitus.</p> <p>Observation and interview, with the resident on April 28, 2014, at 12:01 p.m., in the resident's room revealed the resident had concerns with dentures. Continued interview revealed the resident has not experienced any weight loss and does not have any problem eating.</p> <p>Interview with the Director of Nursing on April 30, 2014, at 11:38 a.m., in the facility conference room confirmed the facility had failed to assess the resident's dental needs.</p>	F 272	<p>DON/Designee to perform audit of resident charts for dental assessments to take place for 5 residents/day for 5 days/week for 2 weeks. Then 3 residents/day for 3 days/week for 2 weeks to monitor compliance. Audit information to be documented and presented to QA committee and Administrator quarterly for evaluation of further possible action.</p>	5/23/2014
F 279	<p>483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>	F 279		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	<p>Continued From page 2</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a comprehensive care plan to address depression for one resident (#76), and failed to develop a care plan to address dialysis for one resident (#94) of twenty-one residents reviewed during stage 2.</p> <p>The findings included:</p> <p>Resident #76 was admitted to the facility on April 22, 2014, with diagnoses including Migraines with Right Sided Weakness, Deconditioning, and Variable Expressive Speech.</p> <p>Medical record review of the current Physician's medication orders revealed, "...Paxil (antidepressant) 20 mg (milligrams) for depression..." Continued medical record review of the care plan updated April 29, 2014, revealed no</p>	F 279	<p>Resident #76 was assessed by DON/designee without any indication of negative effects and care plan was immediately updated for patient care needs.</p> <p>All care plans for patients with depression diagnosis were assessed by DON/designee and no other care plans were found to be deficient.</p> <p>DON/Designee to inservice all registered nurses on patient assessment and care plan documentation by 5/20/14.</p> <p>DON/Designee to audit care plans of patients with depression diagnosis 3 residents/day for 3 days/wk for 2 weeks. 2 residents/day for 2 days/wk for 2 weeks to monitor compliance. Documentation to be presented to QA committee and administrator for evaluation for possible further action.</p> <p>Resident #94 was assessed by DON/designee for dialysis/renal needs without any negative effects indicated, and it was found that the patient's order for dialysis was being followed and care plan was immediately updated to reflect patient care needs.</p> <p>All care plans for patients with order for dialysis were assessed by DON/designee and no other care plans were found to be deficient.</p> <p>DON/Designee to inservice all registered nurses on patient assessment and care plan documentation by 5/20/14.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445356	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/30/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	Continued From page 3 documentation of the depression.  Resident #94 was admitted to the facility on April 23, 2014, with diagnoses including Cerebral Vascular Accident, Vancomycin Resistant Enterococcus, and Dialysis.  Medical record review of the Long Term Care Physician orders dated April 23, 2014, revealed "...dialysis Tue (Tuesday), Thur (Thursday), Sat (Saturday)...no BP LUE (left upper extremity)..."  Interview with the Director of Nursing on April 29, 2014, at 3:30 p.m., in the facility conference room confirmed the care plan failed to address the depression for resident #76 and failed to address the dialysis for resident #94.	F 279	DON/Designee to audit all current dialysis patients and new dialysis admissions 2x/wk for 2 weeks and then 1x/wk for 2 weeks to monitor compliance. Audit information to be documented and presented to QA committee and Administrator quarterly for evaluation of further possible action.	5/23/2014	
F 371	483.35(l) FOOD PROCURE, SS=F STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to maintain a sanitary kitchen by failing to properly store foods and failing to provide proper hand sanitation equipment for one of one kitchen reviewed.	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445356	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/30/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601	
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			(X5) COMPLETION DATE

F 371 Continued From page 4

The findings included:

Observation on April 28, 2014, at 10:10 a.m., with the Dietary Manager, in the kitchen prep area revealed the following items all opened, undated and unlabeled: three boxes of rice, one box of cream of wheat cereal, one bag of sugar, one bag of pancake mix, one bag of flour, one box of corn starch, one box of grits, two bags of instant mashed potatoes, one bag of biscuit gravy mix, one bag of chicken gravy mix, one package of ranch dressing mix, one bag of pasta mix, one bag of beef gravy mix, three bags of french fried onion mix, and one bag of pork gravy mix.

Observation on April 28, 2014, at 10:20 a.m., with the Dietary Manager, in the walk-in freezer revealed the following items all opened, undated, and unlabeled: one box of pork sausage puree patties, one bag of broccoli, one bag of onion rings, one bag of french fries, and one bag of diced potatoes.

Observation on April 28, 2014, at 10:25 a.m., with the Dietary Manager, in the walk-in refrigerator, revealed the following items all opened, undated, and unlabeled: one package of sliced cheese and one tube of whipped cream. Further observation in the dry storage room revealed the following items all opened, undated, and unlabeled: one bag of granola cereal, one bag of bread crumbs, and two bags of egg noodles.

Review of facility policy, Food and supply Storage Procedures, revised January 2012 revealed "...cover, label and date unused portions and open packages..."

F 371

All open, unlabeled and undated items were immediately disposed of by dietary manager. All other items located in the kitchen prep area, freezer, refrigerator and dry storage areas were immediately assessed and no other packages or containers were found to be deficient.

Dietary Manager/designee to inservice food service personnel on labeling, dating, and open packages by 5/14/14. Monitoring of this information added to Basic Sanitation Checklist form.

Dietary Manager/Designee to assess dietary department for open, unlabeled and undated items 5x/wk for 2 weeks, then 3 days/wk for 2 weeks to monitor compliance.

Dietary Manager to communicate this information to QA committee and administrator for evaluation for further possible action.

5/23/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445356	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/30/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 5</p> <p>Interview with the Dietary Manager on April 28, 2014, at 10:40 a.m., in the kitchen confirmed the facility had failed to follow facility policy for food storage.</p> <p>Observation with the Dietary Manager on April 28, 2014, at 10:40 a.m., at the hand washing sink in the kitchen revealed two of two trash cans with no foot pedals to prevent cross contamination after sanitizing the hands.</p> <p>Interview with the Dietary Manager on April 28, 2014, at 10:40 a.m., in the kitchen confirmed the facility had failed to prevent cross contamination by not providing proper hand sanitation equipment.</p>	F 371	<p>Trash cans in hand washing areas without foot pedals were replaced with trash cans which utilize foot pedals on 5/3/14.</p> <p>Other trash cans located at hand washing areas were assessed and no other receptacles were found to be deficient.</p> <p>Dietary manager to monitor use of garbage container 5x/wk for 2 weeks and then 3x/wk for 2 weeks to monitor compliance.</p> <p>Dietary manager/designee to inservice food service personnel on handwashing and use of trash cans with foot pedals to avoid cross contamination by 5/19/14.</p> <p>Functionality of trash cans to be added to monthly kitchen inspection.</p>	5/23/2014	

## Division of Health Care Facilities

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN9004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  04/30/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000: Initial Comments	A licensure survey was completed on April 28-30, 2014, at Princeton Transitional Care. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE

3384

CDDP

TKDA11

Administrator

5/16/14

If continuation sheet 1 of 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/01/2014  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445356	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING		(X3) DATE SURVEY COMPLETED  04/29/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: NFPA 25, 5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the proper orientation (e.g., upright, pendent, or sidewall). NFPA 25, 5.2.1.1.2 Any sprinkler shall be replaced that has signs of leakage; is painted, corroded, damaged, or loaded; or in the improper orientation.</p> <p>Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were free of corrosion. The findings include: Observation and interview with the Maintenance Director, on April 29, 2014 at 7:55 a.m. confirmed 2 of 10 sprinkler heads in Physical therapy were corroded. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on April 29, 2014.</p>	K 062	<p>Corroded sprinkler heads found in the physical therapy gym were replaced on 5/15/14. All other sprinkler heads located within the resident area were assessed by Facility engineer and no other sprinkler heads were found to be deficient.</p> <p>Administrator to Inservice maintenance director on life safety code for sprinkler system maintenance by 5/13/14. Cleaning and inspecting of all sprinkler heads to be entered into work order system for quarterly completion and documentation by facility engineer.</p> <p>Facility Engineer/designee to perform quarterly assessment of facility sprinkler heads. Documentation to be presented to QA committee and administrator for evaluation for possible further action.</p>	5/23/2014	
K 077 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Piped in medical gas systems comply with NFPA 99, Chapter 4.</p> <p>This STANDARD is not met as evidenced by:</p>	K 077			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

3384

Administrator

5/16/14

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

150

PRINTED: 05/01/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445356	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  04/29/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601		
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K 077	Continued From page 1 Based on observation and interview, it was determined the facility failed to ensure electric installation in storage locations or manifold enclosures for nonflammable medical gases comply with the standards of NFPA 99. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 5-feet above the floor as a precaution against their physical damage.(1999 NFPA 99, 4-3.1.1.2 (a)4) The findings include: Observation with the Maintenance Director on April 29, 2014 at 7:30 AM confirmed the respiratory therapy storage room used for storing 23 E -size oxygen cylinders had electrical switches and outlets located lower than 5-feet above the floor. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on April 29, 2014.	K 077	Excess amount of O2 cylinders were removed from room and reduced to 12 cylinders to comply with regulation by 5/15/14 Other areas of facility were assessed by facility engineer for excessive O2 tanks without indication of further deficiency. Maintenance director/designee to inservice staff members designated to administer O2 on regulatory compliance for O2 storage by 5/23/14 Facility Engineer/designee to perform audit of O2 storage 5x/wk for 2 weeks, and then 3x/wk for 2 weeks to monitor compliance. Documentation to be presented to QA committee and administrator for evaluation for possible further action.	5/23/2014	

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN9004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  04/29/2014
NAME OF PROVIDER OR SUPPLIER  PRINCETON TRANS CARE AT NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2511 WESLEY STREET JOHNSON CITY, TN 37601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the annual Licensure survey conducted on April 29, 2014, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

3384

TKDA21

Administrator

5/16/14

If continuation sheet 1 of 1



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
OFFICE OF HEALTH LICENSURE AND REGULATION  
EAST TENNESSEE REGION  
7175 STRAWBERRY PLAINS PIKE, SUITE 103  
KNOXVILLE, TENNESSEE 37914

June 27, 2014

Mr. Ryan Youngblood, Administrator  
Princeton Transitional Care at North  
2511 Wesley Street  
Johnson City TN 37601

Re: 44-5356

Dear Mr. Youngblood:

The East Tennessee Regional Office of Health Care Facilities conducted a Health and Life Safety Code recertification survey on April 28 - 20, 2014. A desk review of your plan of correction for deficiencies cited as a result of the survey was conducted June 26, 2014. Based on the review, we are accepting your plan of correction and are assuming your facility is in compliance with all participation requirements as of May 23, 2014.

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-594-9396 or by fax: 865-594-5739.

Sincerely,

Karen B. Kirby, R.N.  
Regional Administrator  
ETRO Health Care Facilities

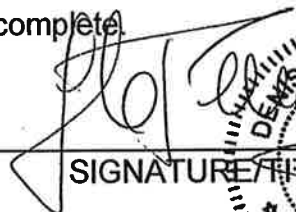
KK:afl


**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF Washington

Grace Pereira, being first duly sworn, says that he/she is the applicant named in this application or his/her lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Tennessee Health Services and Development Agency and T.C.A. § 68-11-1601, *et seq.*, and that the responses to questions in this application or any other questions deemed appropriate by the Tennessee Health Services and Development Agency are true and complete.

  
\_\_\_\_\_  
SIGNATURE/TITLE



Sworn to and subscribed before me this 11<sup>th</sup> day of September, 2014 a Notary  
(Month) (Year)

Public in and for the County of Washington State of Tennessee.

Denise R. Clark

NOTARY PUBLIC

My commission expires September 29, 2015.  
(Month/Day) (Year)

# **SUPPLEMENTAL - #1**

## **-Copy-**

Johnson City Medical Center

**CN1409-039**

**SUPPLEMENTAL**  
**#1**

**1. Section A, Applicant Profile, Item 5 (Management/Operating Entity)**

A non-binding letter of intent for management services from Signature Healthcare in Attachment 1 is noted. Please complete Item 5 of the application and resubmit page 4.

Please attach a copy of the draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule.

Please describe the management entity's experience in providing management services for this type of facility, which is the same or similar to the applicant facility. Please also describe the ownership structure of the management entity.

**RESPONSE:** Item 5 has been revised and the updated page 4 of the original application is provided in Attachment 1 along with the requested draft management agreement.

Signature HealthCARE was founded in November 2007 through an acquisition of assets of Home Quality Management, Inc. Today Signatures owns and operates over 120 long-term health care and rehabilitation sites across ten states, including Kentucky, Indiana, Ohio, Tennessee, Virginia, Florida, Georgia, Alabama, Maryland and North Carolina. A growing number of Signature centers are earning five-star ratings from the Centers for Medicare & Medicaid Services which speaks to the quality of their care. Signature's vision is "to radically change the landscape of long term care forever" and its mission is that *"our family-based organization will revolutionize the Long Term Care industry through a culture of resident-centered healthcare services, personalized spirituality, real quality of life initiatives and stakeholder education and empowerment, to earn the trust of every resident, family and community we serve."*

Signature has been on the US New and World Report for Best Nursing Homes for the past four years (2011 - 2014). They are a very experienced post-acute care operator with services across a variety of areas including nursing center, rehabilitation centers, and home care, as well as several critical access hospitals.

The management entity will be a Delaware limited liability company and Signature HealthCARE, LLC owns 100% of that entity.

**2. Section A, Applicant Profile, Item 13**

New TennCare Managed Care Contract with the Bureau of TennCare will take effect January 1, 2015 with full statewide implementation for AmeriGroup,

BlueCare Tennessee and United Healthcare. Please indicate the stages of contract discussions with each MCO for these new contracts.

**RESPONSE:** Mountain States Health Alliance already has existing contracts in place with BlueCare Tennessee and United Healthcare (AmeriChoice). MSHA is currently in contract discussions with AmeriGroup as there is not an existing contract already in place. These discussions are progressing and MSHA estimates it is about a third of the way to completing that contract agreement.

### **3. Section A, Project Description, Item I**

The applicant has requested consent calendar for this project. Please address the reason consent calendar is being requested as it relates to each of the following: 1) Need, 2) Economic Feasibility, and the 3) Orderly development to health care.

What are the current and proposed plans for Franklin Transitional Care (13 beds).

**RESPONSE:** The request to be placed on the consent calendar was made because this project only involves the relocation of an existing service 4 miles away within the same city and the same county. Princeton Transitional Care is an existing service and the request is to relocate from its current location at Quillen Rehabilitation Hospital 4 miles away to Johnson City Medical Center. All entities are owned by Mountain States Health Alliance and in fact, Quillen Rehabilitation Hospital is technically a satellite campus of Johnson City Medical Center.

This project is not requesting any additional beds. The need for the project is based on internal operational opportunities to enhance the programmatic space and infrastructure at Quillen by moving PTC to Johnson City Medical Center. The economic feasibility is demonstrated by the minimal costs associated with the project. The orderly development to healthcare is demonstrated by the opportunity to enhance services at QRH by freeing up space currently used by PTC. Furthermore, PTC will continue to be available to the community within Johnson City Medical Center. This move 4 miles away will have no bearing on existing providers in the market.

Franklin Transitional Care's license is currently on inactive status. On September 10, 2014 the Board for Licensing Health Care Facilities met and granted FTC's request for its license to be on inactive status as MSHA and Signature HealthCARE develop an elder care campus that will include independent living, assisted living, and skilled nursing care. Once that campus is opened (targeting June 2016), the intent is to reactivate FTC's license and operate those beds on the new campus.

**4. Section B, Project Description, Item 1I.A. and 1I.B.**

The applicant notes total construction cost of \$18,000 or \$1.26 PSF. However, the Project Costs Chart construction cost is \$10,500 which calculates to .73 cents cost per square foot. Please revise and submit a replacement page and also square footage and cost per square footage chart.

The notation of 13 FTC SNF beds in the table of page 9 as being suspended is noted. However, please clarify what is meant as being "suspended".

**RESPONSE:** The replacement page is provided in Attachment 2 as well as a revised square footage and cost per square footage chart.

The reference to FTC's status as suspended is related to their license being on inactive status as noted in response to supplemental question 3.

**5. Section B, (Project Description) Item III (Plot Plan)**

Please submit a revised plot plan that indicates the location of the applicant's structure and size (acres).

**RESPONSE:** A revised plot plan with the requested modifications is provided in Attachment 3.

**6. Section C, Need Item 2.b. (Specific Criteria -Construction, Renovation, Expansion, and Replacement)**

The Princeton Transitional Care Volume chart is noted. However, please clarify how the applicant expects to achieve 9,516 patient days in Year One while patient days have been in decline from 11,131 days in 2010 to 8,839 in 2014.

**RESPONSE:** Despite the decline in volumes in 2010 and 2011, Princeton Transitional Care has maintained volumes near 9,000 patient days for the past three years. The projection to grow patient days to 9,516 by Year 2 is based on the continued steady volumes plus focused resources within Johnson City Medical Center to ensure appropriate patient placement. As noted in the original application, Signature HealthCARE is a regional expert in this area with 123 locations over ten states. Some of the expertise they will bring includes resources to educate providers when skilled nursing care is a viable placement option. It is believed that there are some patients who are appropriate for skilled nursing care who are currently kept longer in the acute care setting. Appropriate education and close relations with patient resource management will ensure patients are placed in the appropriate setting as quickly as possible, especially when one resource option is available within the hospital walls.

**7. Section C, Need Item 4(a) 4.(b) (Specific Criteria -Construction, Renovation, Expansion, and Replacement)**

The applicant has provided a practical need to change the proposed new site. As directed, please also provide some significant legal and financial need.

Please clarify if patient costs will increase as a result of the proposed relocation.

**RESPONSE:** The question states the applicant should provide practical, legal or financial need and therefore the most appropriate response, which is the practical need, was provided in the original application. There is a legal need in that once HealthSouth and MSHA complete their joint venture, that entity will purchase QRH and this essentially displaces PTC as PTC is not part of the purchase agreement.

Patient costs are not anticipated to increase as a result of the proposed relocation.

**8. Section C, Need Item 2**

Please indicate how the Certificate of Need process is related to the applicant's long-range development plans. If applicable, a brief background of previously approved CON projects related to this proposed project would be helpful.

**Response:** As described in the original application, this request to relocate PTC will enable MSHA to move forward with its long-range plan of enhancing its post-acute care service offerings in Washington County. This long-range plan includes multiple phases over time, with the first occurring in the near term, which is the enhancement of rehabilitation services at QRH. In order to leverage the expertise that will be brought to QRH by the new relationship with HealthSouth, expansion of QRH's programmatic space and improvements to its infrastructure necessitate additional square footage which PTC currently occupies. By relocating PTC to JCMC, the first phase of the long-term plan to enhance post-acute services can proceed. The second phase of the long-term plan is to leverage expertise of MSHA's second post-acute partner in Washington County, which is Signature HealthCARE. By engaging Signature in an agreement to manage PTC at its proposed location within JCMC, MSHA will be able to leverage Signatures' expertise and resources to enhance the quality of care provided to this patient population. The third phase of the long-term plan will be the completion of an eldercare campus in Johnson City. Once that campus is developed, MSHA and Signature will seek to move all of the PTC and FTC skilled nursing care beds to the campus that will also contain independent living and assisted living housing options.

There have not been any previously approved CON projects directly related to this proposed project.

**9. Section C, Need Item 4.A**

Your response to this item is noted. Using population data from the Department of Health, enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, please complete the following table and include data for each county in your proposed service area.

**RESPONSE:** As requested, the table below has been populated with demographic data.

<i>Variable</i>	<i>Washington</i>	<i>Carter</i>	<i>Sullivan</i>	<i>Unicoi</i>	<i>Greene</i>	<i>Johnson</i>	<i>Service Area</i>	<i>Tennessee</i>
<b>Current Year (2014), Age 65+</b>	22,459	11,419	32,916	4,198	14,442	3,829	89,263	1,010,447
<b>Projected Year (2018), Age 65+</b>	26,106	12,830	36,290	4,791	16,650	4,279	100,946	1,174,947
<b>Age 65+, % Change</b>	16.2%	12.4%	10.3%	14.1%	15.3%	11.8%	13.1%	16.3%
<b>Age 65+, % Total (PY)</b>	19.0%	22.0%	22.8%	25.2%	22.7%	22.6%	21.6%	16.8%
<b>CY, Total Population</b>	130,206	57,945	158,366	18,685	71,346	18,628	455,176	6,545,936
<b>PY, Total Population</b>	137,400	58,274	159,393	19,003	73,260	18,952	466,642	6,961,361
<b>Total Pop. % Change</b>	5.5%	0.6%	0.7%	1.7%	2.7%	1.7%	2.5%	6.4%
<b>TennCare Enrollees</b>	20,213	6,895	28,715	3,644	13,214	4,009	76,690	1,241,028
<b>TennCare Enrollees as a % of Total Population</b>	15.5%	11.9%	18.1%	19.5%	18.5%	21.5%	16.8%	18.9%
<b>Median Age</b>	39	43.2	45.6	46.2	44.6	44.2	43.8	36.7
<b>Median Household Income</b>	42,995	32,908	40,025	35,415	35,613	30,063	36,170	44,140
<b>Population % Below Poverty Level</b>	17.3%	22.8%	16.9%	22.1%	22.5%	25.4%	19.2%	17.3%

Sources: Bureau of TennCare, US Census Bureau, TN Advisory Commission on Intergovernmental Relations, UT Center for Business and Economic Research

**10. Section C. Need, Item 6**

The tables showing utilization of the new facility are noted. Please provide a composite snapshot from the tables in the response by condensing the information into the table below.

**RESPONSE:** To clarify, this request is not for a new facility. It is to move an existing service (PTC) from QRH to JCMC. A composite snapshot of utilization for PTC is provided below.

**PTC - Historical and Projected Utilization**  
\* Includes Medicare/Medicaid certified beds

Year	Licensed Beds	*Medicare-certified beds	SNF Medicare ADC	Other skilled ADC	Non skilled ADC	Total ADC	Licensed Occupancy %
2011	34	34	17.8	10.1	n/a	27.9	81.9%
2012	34	34	16.2	7.4	n/a	23.6	69.5%
2013	34	34	16.5	8.0	n/a	24.5	72.1%
Year 1- 2016	34	34	16.2	8.2	n/a	24.4	71.9%
Year 2- 2017	34	34	17.3	8.8	n/a	26.1	76.7%

**11. Section C. Economic Feasibility 1 (Project Cost Chart)**

The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Please indicate the fair market value of the property as it relates to the proposed project.

Please clarify if there are any moving and set-up costs associated with the proposed relocation.

**RESPONSE:** There is not a lease option associated with this project. Signature HealthCARE will be managing the skilled nursing beds, but MSHA will continue to own the beds and the space. The moving and set-up costs are included in the contingency costs.

**12. Section C. Economic Feasibility 3**

The applicant notes total construction cost of \$18,000 or \$1.26 PSF. However, the Project Costs Chart construction cost is \$10,500 which calculates to .73 cents cost per square foot. Please revise and resubmit a replacement page.

Please refer to the following HSDA web-site and compare the renovation costs to approved hospital project construction costs between 2011-2013.

[http://tennessee.gov/hsda/applicants\\_tools/docs/Construction%20Cost%20Per%20Square%20Foot%20charts.pdf](http://tennessee.gov/hsda/applicants_tools/docs/Construction%20Cost%20Per%20Square%20Foot%20charts.pdf)

**RESPONSE:** A revised page 27 is included in Attachment 4. There are very minimal costs associated with this project totaling \$18,000, of which \$10,500 is associated directly with construction (\$0.73 per square foot).

Based on the information provided at the HSDA website, these costs are very minimal compared to other hospital construction costs for projects approved between 2011 and 2013. While there are some slight refurbishments needed, the space at JCMC previously housed skilled nursing care in the past, so the project

costs are considerably lower than other approved renovation projects. According to the HSDA summary information, the first quartile of renovated construction costs for hospital approved projects was \$107.15 per square foot. This project would only incur renovation construction costs of \$0.73 per square foot.

**13. Section C. Economic Feasibility Item 4 (Historical Data Chart and Projected Data Chart)**

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised information Historical and Projected Data Charts provided at the end of this requests for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

There appears to be calculation errors in the Historical Data Chart for years 2012, 2013, and 2014. Please recheck all figures when transitioning figures to the new historical data chart located at the end of this document.

**RESPONSE:** Revised historical and projected data charts are provided in Attachment 5.

**14. Section C. Economic Feasibility, Item 8**

The applicant expects losses in Year One and Year Two of the proposed project. Please indicate when the applicant expects to break-even.

**RESPONSE:** It is projected to break-even in Year 3. At this time, it is anticipated PTC will be part of the new eldercare campus and it will be have complete access to all Signature HealthCARE's resources. While PTC is still at JCMC, there are some operational components that Signature will not be able to fully implement until the unit is part of the new eldercare campus that is in MSHA's long range plan.

**15. Section C. Economic Feasibility 9**

The breakdown of TennCare/Medicaid and Medicare revenue for 2014 is noted. However, please direct the response of the question to Year One of the proposed project and resubmit.

**RESPONSE:** The breakdown of revenue by payor for Year One of the proposed project is indicated in the table below.

<b>Projected Year One PAYOR MIX</b>	<b>Total Charges</b>	<b>Payor Mix by Charges</b>
<b>01 MEDICARE</b>	\$ 7,928,233	35.98%
<b>02 MANAGED MEDICARE</b>	\$ 7,626,269	34.61%
<b>03 MEDICAID</b>	\$ 279,662	1.27%
<b>04 TENNCARE</b>	\$ 1,245,389	5.65%
<b>05 MANAGED CARE</b>	\$ 311,990	1.42%
<b>06 BLUE CROSS</b>	\$ 1,111,534	5.04%
<b>07 UNITED - RIVER VALLEY</b>	\$ 399,516	1.81%
<b>08 COMMERCIAL</b>	\$ 348,425	1.58%
<b>09 SELF PAY</b>	\$ 2,723,384	12.36%
<b>10 OTHER</b>	\$ 58,683	0.27%
<b>TOTAL</b>	\$ 22,033,086	100%

**16. Section C. Orderly Development , Item 7 (b)**

Please provide a copy of the latest Joint Commission survey.

RESPONSE: A copy of JCMC's latest Joint Commission survey is included in Attachment 6.

**17. Other**

RESPONSE: A copy of the signed affidavit is included in Attachment 7.

**ATTACHMENT 6**  
**JCMC's Joint Commission Survey**

Johnson City Medical Center  
400 North State of Franklin Rd  
Johnson City, TN 37604

**Organization Identification Number: 7844**

**Program(s)**

Hospital Accreditation

Behavioral Health Care Accreditation

**Survey Date(s)**

04/02/2012-04/05/2012

**Executive Summary**

**Hospital Accreditation :** As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

---

**Behavioral Health Care Accreditation :**

As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

**The Joint Commission  
Summary of Findings**

**SUPPLEMENTAL #1**

**September 29, 2014**

**10:30 am**

**Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day this report is posted to your organization's extranet site:**

<b>Program:</b>	Hospital Accreditation Program	
<b>Standards:</b>	EC.02.03.01	EP1
	EC.02.03.05	EP4
	EM.02.02.15	EP5
	LS.02.01.20	EP1,EP13
	MM.03.01.03	EP2
	NPSG.15.01.01	EP1
	PC.01.02.07	EP1,EP3
	PC.03.01.07	EP7
	UP.01.01.01	EP1

**Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day this report is posted to your organization's extranet site:**

<b>Program:</b>	Hospital Accreditation Program	
<b>Standards:</b>	HR.01.04.01	EP2
	LD.04.01.01	EP2
	LS.02.01.30	EP2
	LS.02.01.35	EP4
	MS.01.01.01	EP10
	RC.01.01.01	EP19

**The Joint Commission  
Summary of CMS Findings**

**September 29, 2014  
10:30 am**

**CoP:** §482.24      **Tag:** A-0431      **Deficiency:** Standard  
**Corresponds to:** HAP  
**Text:** §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)(ii)	A-0454	HAP - RC.01.01.01/EP19	Standard

**CoP:** §482.41      **Tag:** A-0700      **Deficiency:** Standard  
**Corresponds to:** HAP  
**Text:** §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(b)(1)(i)	A-0710	HAP - EC.02.03.05/EP4, LS.02.01.20/EP1, EP13, LS.02.01.30/EP2, LS.02.01.35/EP4	Standard

**CoP:** §482.51      **Tag:** A-0940      **Deficiency:** Standard  
**Corresponds to:** HAP  
**Text:** §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP Standard	Tag	Corresponds to	Deficiency
§482.51(b)	A-0951	HAP - EC.02.03.01/EP1	Standard

**CoP:** §482.52      **Tag:** A-1000      **Deficiency:** Standard  
**Corresponds to:** HAP  
**Text:** §482.52 Condition of Participation: Anesthesia Services

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.52(b)(3)	A-1005	HAP - PC.03.01.07/EP7	Standard

The Joint Commission  
FindingsSeptember 29, 2014  
10:30 am

**Chapter:** Emergency Management  
**Program:** Hospital Accreditation  
**Standard:** EM.02.02.15

ESC 45 days

**Standard Text:** During disasters, the hospital may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration.  
 Note: While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster.

**Primary Priority Focus Area:** Credentialed Practitioners

**Element(s) of Performance:**

5. Before a volunteer practitioner who is not a licensed independent practitioner is considered eligible to function as a practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and one of the following:



- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license, certification, or registration
- Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice)
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by hospital staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster

**Scoring Category :A**

**Score :** Insufficient Compliance

**Observation(s):**

EP 5

Observed in Document Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

During a review of the hospital disaster privileging requirements for the medical staff it was noted that a valid government-issued photo identification card was not always required in addition to one of the other listed credentials, for a volunteer practitioner who is not a licensed independent practitioner.

**Chapter:** Environment of Care  
**Program:** Hospital Accreditation  
**Standard:** EC.02.03.01  
**Standard Text:** The hospital manages fire risks.  
**Primary Priority Focus Area:** Physical Environment

ESC 45 days

**Element(s) of Performance:**

1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion.



**Scoring Category :C**

**Score :** Partial Compliance

**Observation(s):**

EP 1

§482.51(b) - (A-0951) - §482.51(b) Standard: Delivery of Service

Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed in elevator mechanical room BK 004 an electrical junction box did not have a cover plate installed and therefore did not minimize the potential for harm from fire and smoke.

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed above the ceiling at door # 1 D 121, an electrical junction box did not have a cover plate installed and therefore did not minimize the potential for harm from fire and smoke.

**Chapter:** Environment of Care

**Program:** Hospital Accreditation

**Standard:** EC.02.03.05

ESC 45 days

**Standard Text:**

The hospital maintains fire safety equipment and fire safety building features.

Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

4. Every 12 months, the hospital tests visual and audible fire alarms, including speakers. The completion date of the tests is documented.

Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).



**Scoring Category :C**

**Score :** Insufficient Compliance

**Observation(s):**

EP 4

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Document Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the document review it was observed that the hospital did not have documentation that all Audio and Visual devices were tested every 12 months as required by the NFPA. At time of survey there was no documentation of audio / visual device located in room 1628 was tested in 2010 and 2011.

Observed in Document Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the document review it was observed that the hospital did not have documentation that all Audio and Visual devices were tested every 12 months as required by the NFPA. At time of survey there was no documentation of audio / visual device located in room 0934 was tested in 2010 and 2011.

Observed in Document Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the document review it was observed that the hospital did not have documentation that all Audio and Visual devices were tested every 12 months as required by the NFPA. At time of survey there was no documentation of audio / visual device located in room BK 05 was tested in 2010 and 2011.

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**Chapter:** Human Resources  
**Program:** Hospital Accreditation  
**Standard:** HR.01.04.01  
**Standard Text:** The hospital provides orientation to staff.  
**Primary Priority Focus Area:** Orientation & Training  
**Element(s) of Performance:**

2. The hospital orients its staff to the key safety content before staff provides care, treatment, and services. Completion of this orientation is documented. (See also EC.02.03.01, EP 10 and IC.01.05.01, EP 6)



ESC 60 days

**Scoring Category :C**

**Score :** Partial Compliance

**Observation(s):**

EP 2

Observed in Individual Tracer at Mountain States Rehabilitation (415 State of Franklin Road, Johnson City, TN) site. It was noted that there was no documented evidence that one contracted housekeeping staff had been oriented to the key safety contents identified by the organization before providing services.

Observed in Tracer Activities at Mountain States Rehabilitation (415 State of Franklin Road, Johnson City, TN) site. It was noted that there was no documented evidence that a second contracted housekeeping staff had been oriented to the key safety contents identified by the organization before providing services.

**Chapter:** Leadership  
**Program:** Hospital Accreditation  
**Standard:** LD.04.01.01  
**Standard Text:** The hospital complies with law and regulation.  
**Primary Priority Focus Area:** Organizational Structure  
**Element(s) of Performance:**

ESC 60 days

2. The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations.



**Scoring Category :A**

**Score :** Insufficient Compliance

**Observation(s):**

EP 2

Observed in Individual Tracer at Quillen Rehabilitation Hospital (2511 Wesley Street, Johnson City, TN) site. It was noted that the organization did not comply with CDC's requirement to put the date of the Vaccine Information Statement in the medical records.

**Chapter:** Life Safety  
**Program:** Hospital Accreditation  
**Standard:** LS.02.01.20  
**Standard Text:** The hospital maintains the integrity of the means of egress.  
**Primary Priority Focus Area:** Physical Environment  
**Element(s) of Performance:**

ESC 45 days

1. Doors in a means of egress are unlocked in the direction of egress. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4)



**Scoring Category :A**

**Score :** Insufficient Compliance

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101-2000: 7.1.10.1)



**Scoring Category :C**

**Score :** Insufficient Compliance

**Observation(s):**

**EP 1**

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Woodridge Psychiatric Hospital (403 N State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed at the Woodridge Hospital, 2 exit doors were locked in the means of exit egress and did not meet all of the requirement for allowing locked exits doors. Exit door # 1 was locked with 2 locking devices. A dead bolt lock which needed 1 key to unlock the dead bolt and a maglock which needed another key to unlock the maglock. Once the exit door is open it enters into a courtyard in which the gate is locked with another maglock and the only means of unlocking the gate is with the activation of the fire alarm. Exit door # 2 is the same locking arrangement located on a different wing of the hospital.

**EP 13**

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed that exit door # 1 located in the boiler room, was blocked with equipment.

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed that exit door # 2 located in the boiler room, was blocked with equipment.

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed that exit door # 3 located in the lower level D mechanical room, was blocked with equipment.

---

**Chapter:** Life Safety  
**Program:** Hospital Accreditation  
**Standard:** LS.02.01.30

ESC 60 days

**Standard Text:** The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

2. All hazardous areas are protected by walls and doors in accordance with NFPA 101-2000: 18/19.3.2.1. (See also LS.02.01.10, EP 5; LS.02.01.20, EP 18) Hazardous areas include, but are not limited, to the following:



Boiler/fuel-fired heater rooms

- Existing boiler/fuel-fired heater rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New boiler/fuel-fired heater rooms have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.

Central/bulk laundries larger than 100 square feet

- Existing central/bulk laundries larger than 100 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laundries have 1-hour fire-rated walls and 3/4-hour fire-rated doors.
- New central/bulk laundries larger than 100 square feet have sprinkler systems and have 1-hour fire-rated walls and 3/4-hour fire-rated doors.

Flammable liquid storage rooms (See NFPA 30-1996:4-4.2.1 and 4-4.4.2)

- Existing flammable liquid storage rooms have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.
- New flammable liquid storage rooms have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors.

Laboratories (See NFPA 45-1996 to determine if a laboratory is a 'severe hazard' area)

- Existing laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the laboratories have walls fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.
- Existing laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. When there is a sprinkler system, the walls are fire rated for 1 hour with 3/4-hour fire-rated doors.
- New laboratories that are severe hazard areas (See NFPA 99-1999: 10-3.1.1) have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- Existing flammable gas storage rooms in laboratories have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)
- New flammable gas storage rooms in laboratories have sprinkler systems and have 2-hour fire-rated walls with 1 1/2-hour fire-rated doors. (See NFPA 99-1999: 10-10.2.2)

Maintenance repair shops

- Existing maintenance repair shops have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with at least 3/4-hour fire-rated doors.
- New maintenance repair shops have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Piped oxygen tank supply rooms (See NFPA 99-1999: 4-3.1.1.2)

- Existing piped oxygen tank supply rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New piped oxygen tank supply rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Paint shops that are not severe hazard areas

- Existing paint shops that are not severe hazard areas have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the shops have 1-hour fire-rated walls with 3/4-hour fire-rated doors.
- New paint shops that are not severe hazard areas have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

Soiled linen rooms

- Existing soiled linen rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour

**The Joint Commission  
Findings****September 29, 2014****10:30 am**

fire-rated walls with 3/4-hour fire-rated doors.

- New soiled linen rooms have sprinkler systems and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

**Storage rooms**

- Existing storage rooms for combustible materials larger than 50 square feet have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

- New storage rooms for combustible materials 50 to 100 square feet are sprinklered, resist the passage of smoke, and have doors with self-closing or automatic-closing devices.

- New storage rooms for combustible materials larger than 100 square feet are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

**Trash collection rooms**

- Existing trash collection rooms have sprinkler systems, resist the passage of smoke, and have doors with self-closing or automatic-closing devices; or the rooms have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

- New trash collection rooms are sprinklered and have 1-hour fire-rated walls with 3/4-hour fire-rated doors.

**Scoring Category :C****Score :** Partial Compliance**Observation(s):****EP 2**

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed that the soiled utility room door located in the PACU department, did not close and latch properly.

Observed in Tracer Activities at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During a tour of the Ambulatory Surgery area, it was observed that the door to the Soiled Holding Room did not close and latch properly.

**Chapter:** Life Safety**Program:** Hospital Accreditation**Standard:** LS.02.01.35**ESC 60 days****Standard Text:** The hospital provides and maintains systems for extinguishing fires.**Primary Priority Focus Area:** Physical Environment

**Element(s) of Performance:**

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.2)



**Scoring Category :C**

**Score :** Partial Compliance

**Observation(s):**

EP 4

§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101@2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: [http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html).

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

This Standard is NOT MET as evidenced by:

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed that cables were tie wrapped to the sprinkler piping located in the lower level D mechanical room.

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During the building tour it was observed that cables and a/c duct, were laying across the sprinkler piping above the ceiling at door # 7000.

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**Chapter:** Medical Staff  
**Program:** Hospital Accreditation  
**Standard:** MS.01.01.01

ESC 60 days

**Standard Text:** Medical staff bylaws address self-governance and accountability to the governing body.

**Primary Priority Focus Area:** Organizational Structure

**Element(s) of Performance:**

10. The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.



**Scoring Category :A**

**Score :** Insufficient Compliance

**Observation(s):**

EP 10

Observed in Document Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

The existing medical staff bylaws do not include a process to manage conflict between the medical staff and the medical executive committee. New medical staff bylaws have been written and are almost ready for submission for approval.

---

**Chapter:** Medication Management

**Program:** Hospital Accreditation

**Standard:** MM.03.01.03

ESC 45 days

**Standard Text:** The hospital safely manages emergency medications.

**Primary Priority Focus Area:** Medication Management

**Element(s) of Performance:**

2. Emergency medications and their associated supplies are readily accessible in patient care areas. (See also PC.03.01.01, EP 8)



**Scoring Category :A**

**Score :** Insufficient Compliance

**Observation(s):**

EP 2

Observed in Building Tour at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

During a tour of the MRI and CT imaging department it was noted that the pediatric crash cart did not contain a Broselow tape as required by the color coded cart.

Another pediatric crash cart from another department contained the 2007B edition while the current Broselow tape is now a 2011 edition.

---

**Chapter:** National Patient Safety Goals

**Program:** Hospital Accreditation

**Standard:** NPSG.15.01.01

ESC 45 days

**Standard Text:** Identify patients at risk for suicide.  
Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

**Primary Priority Focus Area:** Assessment and Care/Services

**Element(s) of Performance:**

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.



**Scoring Category :C**

**Score :** Insufficient Compliance

**Observation(s):**

EP 1

Observed in Individual Tracer at Woodridge Psychiatric Hospital (403 N State of Franklin Road, Johnson City, TN) site. There was no documentation that a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide had been completed for this patient who had been involuntarily committed to the inpatient unit, then transferred to the dual diagnosis unit.

Observed in Tracer Activities at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

During the tour of the Pediatric ED, screening for suicide was completed on patients, but there was no evidence of a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide. The room used for these patients was not able to provide the safety needed to house a potentially suicidal patient. Leadership explained that a patient with this diagnosis would be moved to the main ED, however staff did not seem to be aware of this process.

Observed in the Emergency Department at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

During an individual patient tracer it was noted that there had not been a risk assessment completed that identified specific environmental features that may increase or decrease the risk for suicide.

---

**Chapter:** National Patient Safety Goals

**Program:** Hospital Accreditation

**Standard:** UP.01.01.01

ESC 45 days

**Standard Text:** Conduct a preprocedure verification process.

**Primary Priority Focus Area:** Information Management

**Element(s) of Performance:**

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.

Note: The patient is involved in the verification process when possible.



**Scoring Category :A**

**Score :** Insufficient Compliance

**Observation(s):**

EP 1

Observed in Document Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

During a review of the printed operating room schedule for Day 2 of the survey it was noted that an "open lung biopsy thoracotomy" was scheduled with no documentation of left or right chest.

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**Chapter:** Provision of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** PC.01.02.07

ESC 45 days

**Standard Text:** The hospital assesses and manages the patient's pain.

**Primary Priority Focus Area:** Assessment and Care/Services

**Element(s) of Performance:**

1. The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient's condition. (See also PC.01.02.01, EP 2; RI.01.01.01, EP 8)



**Scoring Category :C**

**Score :** Partial Compliance

3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria.



**Scoring Category :C**

**Score :** Insufficient Compliance

**Observation(s):**

**EP 1**

Observed in Individual Tracer at Woodridge Psychiatric Hospital (403 N State of Franklin Road, Johnson City, TN) site. There was no documentation that a pain assessment had been completed for this patient admitted to the Poplar unit.

Observed in Individual Tracer at Regional Cancer Center at JCMC (1 Professional Park Drive, Suite 21, Johnson City, TN) site.

There was no documentation that a pain assessment had been completed for a patient with a history of chronic pain who was admitted to the IOP.

**EP 3**

Observed in Record Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

During a closed record review of a pediatric patient undergoing sedation for a fractured arm in the Pediatric ED, there was not evidence of a pain reassessment by the nurse caring for the patient.

Observed in the Post Partum Unit at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

During an individual patient tracer it was noted that the patient had not had their pain reassessed after undergoing a circumcision or before being discharged from the hospital several hours after the procedure.

Observed in the Post Partum Unit at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site.

During an individual patient tracer it was noted in a second record that the patient had not had their pain reassessed after undergoing a circumcision.

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**Chapter:** Provision of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** PC.03.01.07

ESC 45 days

**Standard Text:** The hospital provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.

**Primary Priority Focus Area:** Assessment and Care/Services

**Element(s) of Performance:**

7. For hospitals that use Joint Commission accreditation for deemed status purposes:  
A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.



**Scoring Category :A**

**Score :** Insufficient Compliance

**Observation(s):**

EP 7

§482.52(b)(3) - (A-1005) - [The policies must ensure that the following are provided for each patient:]

(3) A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.

This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During an individual tracer on a nephrology patient on 5500, a review was completed on a surgical procedure she had related to access for dialysis. There was no evidence of a postanesthesia evaluation on the record. This patient had the surgery greater than 48 hours in the past.

Observed in Record Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During review of a closed record it was noted that a post anesthesia evaluation had not been documented as completed on a patient who had undergone anesthesia for a Cesarean Section.

Observed in Individual Tracer at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During a general surgery patient tracer it was noted that the postanesthesia evaluation was blank although signed, dated, and timed.

Observed in Individual Tracer at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During an orthopedic surgery patient tracer it was noted that the postanesthesia evaluation was not done after more than 48 hours post-op.

---

**Chapter:** Record of Care, Treatment, and Services

**Program:** Hospital Accreditation

**Standard:** RC.01.01.01

ESC 60 days

**Standard Text:** The hospital maintains complete and accurate medical records for each individual patient.

**Primary Priority Focus Area:** Assessment and Care/Services

**Element(s) of Performance:**

19. For hospitals that use Joint Commission accreditation for deemed status purposes:  
All entries in the medical record, including all orders, are timed.



**Scoring Category :C**

**Score :** Insufficient Compliance

**Observation(s):**

EP 19

§482.24(c)(1)(ii) - (A-0454) - (ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under

§482.12(c) and authorized to write orders by hospital policy in accordance with State law.

This Standard is NOT MET as evidenced by:

Observed in Record Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During a closed record review of a patient receiving sedation in the ED at Johnson City Medical Center, a note was signed by the nurse, but not dated or timed.

Observed in Record Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During a closed chart review of patient in the Pediatric ED undergoing sedation for a forearm fracture, nurse entries were entered, authenticated, but not dated and timed.

Observed in Record Review at Johnson City Medical Center Hospital (400 North State of Franklin Road, Johnson City, TN) site for the Hospital deemed service.

During closed record review of a 12 year old patient in the Pediatric ED for a fractured arm. The patient had sedation in the ED to reduce the fracture. On the physician order sheet, there was an MD signature and date and no time noted. Time was not recorded on the nursing care plan and sedation record.

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**ATTACHMENT 7**  
**Signed Affidavit**

September 29, 2014

10:30 am

SEP 29 14 10:30

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF WashingtonNAME OF FACILITY: Johnson City Medical Center, Princeton Transitional Care

I, Grace Pereira, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

[Signature]  
Signature/Title



Sworn to and subscribed before me, a Notary Public, this the 20<sup>th</sup> day of September, 2014, witness my hand at office in the County of Washington, State of Tennessee.

[Signature]  
NOTARY PUBLIC

My commission expires 9/29, 2015.

# **COPY- SUPPLEMENTAL-2**

**Johnson City Medical Center  
CN1409-039**



# MOUNTAIN STATES HEALTH ALLIANCE

SEP 30 11 44 AM '14

September 29, 2014

Ms. Melanie Hill  
Health Services and Development Agency  
Andrew Jackson Building, Ninth Floor  
502 Deaderick Street Nashville, TN 37243

RE: Certificate of Need Application CN1409-039  
Mountain States Health Alliance/Johnson City Medical Center

Dear Ms. Hill:

Please find enclosed the original and two copies of Johnson City Medical Center's response to the Health Services and Development Agency's request for additional supplemental information related to Certificate of Need Application CN1409-039.

If you have any questions please do not hesitate to contact me at 423-302-3378. I look forward to working with you throughout this process.

Sincerely,

Allison M. Rogers  
Vice-President, Strategic Planning

As requested, a description of how the proposed project supports the Five Principles of the State Health Plan is provided below.

*Five Principles for Achieving Better Health*

**1. The purpose of the State Health Plan is to improve the health of Tennesseans.**

**RESPONSE:** Enhancing and expanding post-acute care services in Washington County will help improve the health of Tennesseans in the service area. These services are essential to a well-developed healthcare delivery system and the partnerships MSHA is creating with HealthSouth and Signature HealthCARE will improve these service offerings and aid patients as they seek to obtain their optimal health status after an acute care stay.

**2. Every citizen should have reasonable access to health care.**

**RESPONSE:** The skilled nursing beds at JCMC will be available to all patients regardless of payment source or ability to pay.

**3. The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health care system.**

**RESPONSE:** MSHA seeks to ensure its patients are the most appropriate lowest cost setting available. Post-acute care services have not traditionally been maximized to their full potential, often times leaving patients in an acute care setting perhaps longer than necessary. Developing partnership relationships with HealthSouth and Signature HealthCARE will enable MSHA to more completely leverage these resources which enhances economic efficiencies and creates a more seamless and effective health care delivery system in the local market.

Medicare has been adjusting its post-acute care payment structure to encourage care in the most-efficient, highest quality, and clinically appropriate sites and this project, with the additional resources and expertise MSHA sought out from HealthSouth and Signature HealthCARE, will do just that.

**4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.**

**RESPONSE:** The more effective use of post-acute care services (including skilled nursing care) provides an opportunity to elevate quality of care for patients. MSHA and Signature HealthCARE will work hand-in-hand to reduce readmissions, ensure appropriate and consistent patient placement and utilization trends, all of which will improve the quality of care provided to the skilled nursing patients MSHA serves.

5. **The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.**

**RESPONSE:** This project will support the existing workforce as Signature HealthCARE will bring additional resources and expertise to the staff delivering skilled nursing care. As a large operator of skilled nursing services, this is Signature's core business, and MSHA's skilled nursing workforce will benefit from this additional knowledge all leading to improved care and outcomes for this patient population.

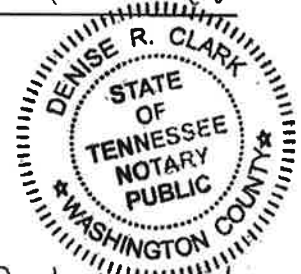
**AFFIDAVIT**

STATE OF TENNESSEE

COUNTY OF WashingtonNAME OF FACILITY: Johnson City Medical Center, Princeton Transitional Care

I, Grace Pereira, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

[Signature] Vice President  
Signature/Title



Sworn to and subscribed before me, a Notary Public, this the 29<sup>th</sup> day of September, 2014, witness my hand at office in the County of Washington, State of Tennessee.

[Signature]  
NOTARY PUBLIC

My commission expires September 29, 2015.





2014 SEP 10 10 30 AM

## LETTER OF INTENT TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Johnson City Press which is a newspaper  
(Name of Newspaper)  
of general circulation in Washington County, Tennessee, on or before September 10, 2014,  
(County) (Month / day) (Year)  
for one day.

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This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: Johnson City Medical Center, an existing hospital provider  
(Name of Applicant) (Facility Type-Existing)

owned by: Mountain States Health Alliance with an ownership type of Not-for-Profit Corporation  
and to be managed by: self intends to file an application for a Certificate of Need

for the relocation Princeton Transitional Care's thirty-four (34) Skilled Nursing Facility beds from James H. and Cecile C. Quillen Rehabilitation Hospital at 2511 Wesley Street, Johnson City, TN 37601 to Johnson City Medical Center at 400 North State of Franklin Road, Johnson City, TN, 37604. No new services will be initiated and no major medical equipment will be purchased. There will be no change in Princeton Transitional Care's or Johnson City Medical Center's licensed bed complement. The estimated project cost is \$21,000.

The anticipated date of filing the application is: September 15, 2014

The contact person for this project is Allison Rogers Vice-President, Strategic Planning  
(Contact Name) (Title)

who may be reached at: Mountain States Health Alliance 303 Med Tech Parkway, Suite 330  
(Company Name) (Address)

Johnson City TN 37604 423/302-3378  
(City) (State) (Zip Code) (Area Code / Phone Number)

Allison M. Rogers 9/9/14 RogersAM@msha.com  
(Signature) (Date) (E-mail Address)

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**The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:**

**Health Services and Development Agency  
Andrew Jackson Building  
500 Deaderick Street, Suite 850  
Nashville, Tennessee 37243**

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The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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**CERTIFICATE OF NEED  
REVIEWED BY THE DEPARTMENT OF HEALTH  
DIVISION OF POLICY, PLANNING AND ASSESSMENT  
615-741-1954**

**DATE:** November 28, 2014

**APPLICANT:** Johnson City Medical Center  
400 North State of Franklin Road  
Johnson City, Tennessee 37604

**CON NUMBER:** CN1409-039

**CONTACT PERSON:** Allison Rogers, Vice President, Strategic Planning  
Mountain States Health Alliance  
303 Med Tech Parkway, Suite 330  
Johnson City, Tennessee 37604

**COST:** \$21,000

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

**SUMMARY:**

The applicant, Johnson City Medical Center, owned by Mountain States Health Alliance, a not-for-profit entity and self-managed is seeking Certificate of Need (CON) approval from the Health Services and Development Agency (HSDA) to relocate Princeton Transitional Care (PTC) a separately licensed 34 bed skilled nursing facility (SNF) within Washington County. PTC is currently located at the James H. and Cecile C. Quillen Rehabilitation Hospital, 2511 Wesley Street in Johnson City (Washington County) referred to as "Quillen" by the applicant.

The project, if approved by the HSDA, will involve the relocation of PTC to the Johnson City Medical Center at 400 N. State of Franklin Road in Johnson City, Tennessee. The 34 bed separately licensed SNF will, as the applicant states, be located in 14,334 square feet of existing space at Johnson City Medical Center. The estimated total project cost is \$21,000. Funding for the project will come from existing cash reserves of Mountain States Health Alliance.

This application has been placed on the Consent Calendar. Tenn. Code Ann. § 68-11-1608 Section (d) states the executive director of Health Services and Development Agency may establish a date of less than sixty (60) days for reports on applications that are to be considered for a consent or emergency calendar established in accordance with agency rule. Any such rule shall provide that, in order to qualify for the consent calendar, an application must not be opposed by any person with legal standing to oppose and the application must appear to meet the established criteria for the issuance of a certificate of need. If opposition is stated in writing prior to the application being formally considered by the agency, it shall be taken off the consent calendar and placed on the next regular agenda, unless waived by the parties.

**GENERAL CRITERIA FOR CERTIFICATE OF NEED**

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan*.

**NEED:**

The service area consists of Carter, Greene, Johnson, Unicoi, Sullivan and Washington counties. The service area population and percentage increase based upon the official population projections of the Tennessee Department of Health is as follows:

Service Area Total Population 2014 and 2018			
County	2014 Population	2018 Population	% of Increase/ (Decrease)
Carter	57,284	57,680	0.7%
Greene	70,187	71,594	2.0%
Johnson	18,094	18,127	0.2%
Unicoi	18,376	18,511	0.7%
Sullivan	158,975	161,136	1.4%
Washington	130,586	138,370	6.0%
<b>Total</b>	<b>453,502</b>	<b>465,418</b>	<b>2.6%</b>

Tennessee Department of Health, Division of Policy, Planning, and Assessment-Office of Health Statistics, 2020, June 2013, Revision

What this project is seeking to accomplish is twofold. First, the CON, as presented, is an initial step that proposes to relocate an existing 34 bed skilled nursing facility, Princeton Transitional Care, from its existing site to vacant space in the Johnson City Medical Center. Secondly, the project enables the Quillen Rehabilitation Hospital to initiate a series of changes designed to transform its post-acute care rehabilitation services. The eventual goal, as set forth by the applicant, is to implement a comprehensive array of senior services incorporated within a Continuing Care Retirement Center (CCRC). Upon completion of the CCRC, the Princeton Transitional Center would be relocated to that site after the construction is completed.

The current CON application CN 1409-039, if approved by the HSDA Board would allow the Princeton Transitional Care SNF to remain in operation at the Johnson City Medical Center site until the new CCRC with the new SNF facility has been completed , a process estimated to take approximately 18-24 months.

**TENNCARE/MEDICARE ACCESS:**

Princeton Transitional Care participates in both the Medicare and TennCare/Medicaid programs. The applicant participates in the following Tenn/Care Managed Care Organizations (as noted on page 6 of the CON application): Americhoice (United Healthcare) and BlueCare (BlueCross). The applicant also participates in the following Behavioral Health Organizations: UBH and Valueoptions.

The applicant states Medicare and Medicare Advantage make up 71% of all charges in 2014 and TennCare/Medicaid constitutes 7% of total charges during the same period.

**ECONOMIC FACTORS/FINANCIAL FEASIBILITY:**

The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

**Project Costs Chart:** The Project Costs Chart is located on page 26 of the CON application. The total estimated project cost is \$21,000.

**Historical Data Chart:** The Revised Historical Data Chart is located in Supplemental 1 as Attachment 5. The applicant reports net operating income of \$50,839,828, \$29,298,637 and \$29,757,103 in years 2012, 2013, and 2014, respectively. These represent Johnson City

Medical Center's net income. The Tennessee Department of Health, Division of Policy, Planning and Assessment-Office of Health Statistics reviewed the Princeton Transitional Care *Joint Annual Report for Nursing Home 2012* and determined the net operating income was (\$149,549) during FY 2012. FY 2013 and FY 2014 financial data are not available at this time.

**Projected Data Chart:** The Projected Data is located in Supplemental 1 as Attachment 5. The applicant projects 8,921 patient days and 9,516 patient days, in years one and two with net operating revenues of \$(141,767) and \$(137,750) each year, respectively. The applicant, in response to a question from HSDA staff, stated that the nursing home would eliminate the deficit in the third year of the project.

The average gross charge for PTC is \$2,470. The average deduction due to contractual adjustments is \$2,055 resulting in an average net charge of \$415.

#### **CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:**

The applicant notes that the Princeton Transitional Care skilled nursing facility will, as does Mountain States Health Alliance and all its facilities including Johnson City Medical Center will continue to work with area health care providers, East Tennessee State University and the James H. Quillen College of Medicine.

The CON application, does not appear to have any negative impact upon other skilled nursing facilities because the project merely relocates an existing hospital based 34 bed skilled nursing facility to another site within Washington County and does not increase or decrease its existing bed capacity.

The applicant provided a copy of the most recent Health and Life Safety Code recertification survey on April 28-30, 2014. Deficiencies were identified by the surveyors and a desk review of the facilities plan of correction (POC) resulted in the determination by the East Tennessee Regional Office that the facility was found to be in compliance with all participation requirements as of May 23, 2014.

#### **SPECIFIC CRITERIA FOR CERTIFICATE OF NEED**

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan*.

#### **CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS**

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

*This project does not involve the addition of beds, services, or medical equipment.*

2. For relocation or replacement of an existing licensed health care institution:
  - a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

*The relocation of PTC, a 34 bed SNF, to Johnson City Medical Center is part of a plan that aims to enhance the provision of skilled nursing services in Washington County.*

*The applicant by transferring the PTC will improve the coordination of SNF services within the Johnson City Medical Center. The cost of the project is \$21,000 and no other alternative would be as cost effective.*

- b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

*The Princeton Transitional Care SNF is projected by the applicant to provide 8,921 patient days of care in year 1 of the project and 9,516 patient days of care in year 2 of the project demonstrating that projected demand will be sufficient demand for the project.*

3. For renovation or expansions of an existing licensed health care institution:

- a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.
- b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

*These criteria do not apply to this project.*